

Select Health of South Carolina Progress Notes



Inside this Issue:

- 2 Antibiotics
First Level Appeals
Universal Provider
Datasource
- 3 NaviNet News
ICD-10 and Version 5010
- 4 Coding Corner
Access to Care

Winter 2010



CMO Update Providing Multicultural Healthcare

By Fred M. Volkman, M.D., FAAP

We are an organization committed to culturally and linguistically appropriate services to help reduce health-care disparities.

While there are many factors that affect health, research suggests that improving cultural competence and language access can reduce poor health outcomes and enhance quality of care.

We recognize that cultural competency is a necessary component of a high quality health plan. And for the past five years, Select Health has worked to provide culturally competent healthcare through our Culturally and Linguistically Appropriate Services (CLAS) program. We aim to establish comprehensive

policies and procedures to ensure that our diverse membership is served in a way that is responsive to cultural and language needs.

In March 2011, Select Health will submit an application for NCQA's Distinction in Multicultural Health Care that was introduced earlier this year. For the distinction, the following five areas will be measured:

- Race/Ethnicity and Language Data Collection
- Access and Availability of Language Services, Practitioner Network Cultural Responsiveness
- Culturally and Linguistically Appropriate Service Programs
- Reducing Healthcare Disparities

I hope that you will support our efforts as we work toward creating an environment of cultural competence for the Medicaid population of South Carolina. ■

Pharmacy News

Medication Recall

Abbott Laboratories and the FDA have notified healthcare professionals and patients about the voluntary withdrawal of Meridia (sibutramine), an obesity drug, from the U.S. market. The withdrawal is due to clinical trial data indicating an increased risk of heart attack and stroke.

For more information, please visit www.fda.gov.

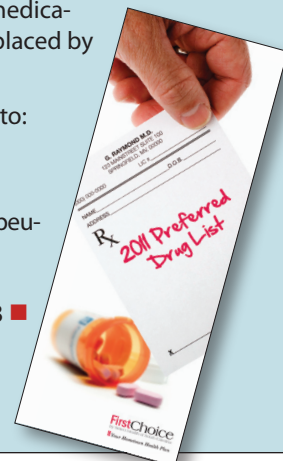
2011 Preferred Drug List

The 2011 Preferred Drug List (PDL) is now available and will be mailed to all providers. For an electronic copy of our PDL or to search the PDL, please visit our website at www.selecthealthofsc.com/firstchoice and go to the Pharmacy section. For additional printed copies of the PDL, please contact your Contract Management Representative.

Providers may request the addition or removal of a medication to this list. Requests to add a medication must include the drug name, rationale for inclusion on the list, role in therapy and medications that may be replaced by the addition.

Please mail requests to:

Select Health
of South Carolina
Pharmacy and Therapeutics Committee
P.O. Box 40849
Charleston, SC 29423 ■



Appointments & After-Hours Access

Each year, Select Health is required to assess the plan's network of physician compliance with appointment availability and after-hours coverage contractual requirements. We review the requirements with you and/or your office staff during your contract management representative's on-site office visits. In addition, we are providing the plan's contractual requirements as listed below.

Appointment Availability Standards:

- Routine visits should be scheduled within four to six weeks.
- For urgent, non-emergency visits, member should be seen within 48 hours.
- For emergency visits, the member should be seen immediately upon presentation.

- Waiting time should not exceed 45 minutes for scheduled appointments of a routine nature.
- Walk-in patients with urgent needs should be seen within 48 hours.

After-Hours Access Standards:

- The primary care provider must be accessible 24 hours a day, seven days a week—personally or through coverage arrangements with a designated contracted primary care physician.
- Other acceptable methods are an answering service and answering machine that provides the member with information on how to reach the physician on call.
- Specialists must be available 24 hours a day, seven days a week through on-call arrangements or emergency department call rotations.

If you have any questions, please contact your Contract Management Representative. ■

Prescribing Antibiotics

According to the National Institute of Allergy and Infectious Diseases, Americans suffer from an average of 3 upper respiratory infections (URI) or common colds a year. Children are particularly susceptible and account for as many as six to 10 URIs a year. Antibiotics are ineffective for viral illness such as colds or flu, most coughs and bronchitis and sore throats not caused by strep.

The importance of performing a strep test for pharyngitis allows for proper identification of the cause of the illness. Appropriate testing and proper antibiotic prescription for a bacterial illness along with family education reinforces the correct use of antibiotics only for bacterial infections.

In the National Committee for Quality Assurance's (NCQA's) The State of Health Care Quality 2010, it was reported that 22% of office visits for the common cold in children under 15 resulted in

antibiotics being prescribed.

We monitor appropriate antibiotic utilization through three standardized HEDIS measures:

- Avoidance of antibiotic treatment in adults with acute bronchitis
- Appropriate treatment for children with upper respiratory infection
- Appropriate testing for children with pharyngitis

Bacteria resistance to antibiotics continues to be a significant health problem. Complications developing from side effects of antibiotics such as rashes, drug allergies, prolonged hospital stays and even death add to the healthcare issues.

The CDC campaign, "Get Smart: Know When Antibiotics Work" provides a wealth of educational information to assist providers and their patients about appropriate use of antibiotics. ■



First Level Appeal Changes

First level appeals are managed by Select Health. A provider, facility or member may appeal any adverse determination.

There are two types of appeals:

- **Clinical appeals** are appropriate when a medical director has denied a requested service because the medical necessity has not been demonstrated. They are reviewed by a physician with a same or similar specialty as the requesting provider.
- **Administrative appeals** are appropriate for adverse determinations that are not based on the application of clinical criteria or medical necessity. These appeals are reviewed by a committee comprised of representatives from Medical Services, Member Services, Network Management and Provider Relations.

Claims payment disputes are not appeals. These should be directed to your provider representative or the Provider Claim Service Unit (PCSU) at 800.575.0418.

Two changes to Select Health's appeal policies have become necessary.

- Federal and state requirements mandate that a provider have written member consent to initiate an appeal. Effective immediately, we are unable to process any appeals without member consent. Appeals submitted without appropriate member consents will be returned to the appealing provider.
- Federal and state requirements mandate that Medicaid managed care plans allow no less than 20 and no more than 90 calendar days from date of action to initiate an appeal. With this requirement, we must modify current appeal submission timeframes. Effective February 1, 2011, members and providers will have 90 calendar days from date of initial denial notification to submit appeal request.

Appeals should be mailed to: Select Health of South Carolina, P.O. Box 40849, Charleston, SC 29433, ATTN: Appeals

Universal Provider Datasource Benefits

The Council for Affordable Quality Healthcare (CAQH) is a nonprofit collaboration of health plans that aims to promote quality interactions between plans and providers.

CAQH developed an easy-to-use system for submitting, updating and distributing all of their credentialing information to authorized, participating plans, called the Universal Provider Datasource (UPD). The UPD allows practitioners to securely submit their credentialing information to multiple health plans and networks by entering the information just once, either online or via fax. The information submitted is available to participating healthcare organizations without cost to the physician. The UPD is supported by numerous nationally accredited medical associations, including the American Medical Association.

Utilizing the UPD system significantly reduces errors typically associated with credentialing, such as misplaced paper documents and incomplete applications. It also reduces the man-hours used to fill out multiple forms, saves administrative costs and minimizes paperwork. Since the re-credentialing process occurs every three years, CAQH sends a quarterly reminder e-mail to the physician's credentialing contact confirming their information is current and complete. Changes submitted are available immediately to the different health plans.

Employing the UPD can reduce cost and time accompanied with numerous credentialing activities, enabling other resources to focus on patient care and satisfaction. ■



NaviNet News

NaviNet allows you to retrieve the most relevant demographic and clinical facts about the healthcare of a First Choice member through our Member Clinical Summary (MCS) Report.

This report comes in a user-friendly format (PDF or Continuity of Care Document) that is timely, accurate and complete. The valuable information returned in this report represents a tremendous opportunity for improving both quality and continuity of care.

The MCS Report returns the following

claim-based data:

- Demographic information (member and PCP)
- Medications (filled within the past 6 months)
- Chronic conditions
- Gaps in care (based on diagnosis compared to clinical recommendations)
- ER visits (within the past 6 months)
- Inpatient admissions (within the past 12 months)
- Office visits (within the past 12 months)

To use this tool, your NaviNet Security Officer must grant security access to users.

Once granted, the MCS Report can be generated from Eligibility and Benefits or from the Reports Inquiry.

The ability to customize the report timeframe is available in the Reports Inquiry option. The default time in the standard report is six months for medications and ER visits and 12 months for inpatient and office visits.

For detailed instructions on how to generate this report, refer to the User Guides listed under the Customer Service menu.

If you have any feedback or questions, please contact your Contract Management Representative. ■

Talking to Your Vendors About ICD-10 and Version 5010: *Tips for Medical Practices*

If you are covered by the Health Insurance Portability and Accountability Act (HIPAA), you need to prepare for two firm deadlines to comply with mandated changes:

January 1, 2012 — for full compliance with Version 5010 standards if you conduct electronic transactions either directly or through a clearinghouse or billing service

October 1, 2013 — for full implementation of ICD-10 code sets

These transition dates are definite. The U.S. Department of Health and Human Services (HHS) established the deadlines on January 16, 2009, and confirmed them on March 5, 2009.

If you submit electronic claims, you need to have completed internal testing of Version 5010 systems in time to begin external testing with your payers, clearinghouses, billing services and other business partners by January 1, 2011.

An important step in preparing for these changes is to talk with any software vendors, clearinghouses or billing services you use to be sure they are ready to provide the support you need. Your vendors will need to have products and services ready well in advance of the compliance deadlines to allow adequate time for testing.

Your vendors can provide you with details about what you need to comply with Version 5010 standards, which replace the Version 4010/4010A standards currently used for electronic transactions. Unlike Version 4010/4010A standards, Version 5010 accommodates the ICD-10 code sets that become effective in 2013.

Start the Conversation

Talk with your vendors now to be sure you can count on them to:

- Have fully functional, compliant products and services ready in plenty of time to allow thorough testing
- Help you avoid potential reimbursement issues

Ask your vendors to establish a comprehensive approach that will deliver compatible products well ahead of the transition deadlines. Consider discussing:

- Systems upgrades/replacements needed for Version 5010/ICD-10

COMPLIANCE TIMELINE

JANUARY 1, 2010

- Payers and providers should begin internal testing of Version 5010 standards for electronic claims

DECEMBER 31, 2010

- Internal testing of Version 5010 must be complete to achieve Level I Version 5010 compliance

JANUARY 1, 2011

- Payers and providers should begin external testing of Version 5010 for electronic claims
- CMS begins accepting Version 5010 claims
- Version 4010 claims continue to be accepted

DECEMBER 31, 2011

- External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance

JANUARY 1, 2012

- All electronic claims must use Version 5010
- Version 4010 claims are no longer accepted

OCTOBER 1, 2013

- Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures
- CPT codes will continue to be used for outpatient services

Visit www.cms.gov/ICD10 for ICD-10 and Version 5010 resources from CMS.

- Costs involved and whether upgrades will be covered
- When upgrades or new systems will be available for testing and implementation
- Customer support and training that they will provide
- How their products and services will accommodate both ICD-9 and ICD-10 as you work with claims for services provided both before and after the transition deadline for code sets

Talking to your vendors now about ICD-10 and Version 5010 will help ensure that your transition goes smoothly.

Version 5010/ICD-10 Resources

The Centers for Medicare & Medicaid Services (CMS) website has official resources at www.cms.gov/ICD10. CMS will continue to add new tools and information to the site throughout the transition.

This fact sheet was prepared as a service to the healthcare industry and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Coding Corner

VAFAC Vaccine Administration

The South Carolina Department of Health and Human Services (SCDHHS) implemented a billing policy requiring providers to include certain information on all Vaccine Assurance for All Children (VAFAC)-supplied vaccine products administered. The appropriate vaccination product(s) CPT code must be included on the claim when filing for reimbursement for the administration of the vaccines. Select Health has also instituted this policy for all providers, including RHCs and FQHCs.

For immunizations covered under the VAFAC program, Select Health will reimburse for the administration using codes 90471-90474. Each administration code must have a corresponding vaccine code included on the claim. There must be a one administration code to one vaccine product code match. These codes are covered for recipients under 19 years old. The list of VAFAC vaccine CPT codes can be found in SCDHHS' Physicians Provider Manual on page 2-35.

There is only one flu vaccine product

for the upcoming flu season. Adult flu vaccines for members age 19 and above should be coded using 90658 and 96372. Flu mist is not covered outside of the VAFAC program.

Diagnosis Coding

Diagnosis codes should accurately reflect the reason for the encounter. Always code to the highest level of specificity and use the code(s) that best describe the reason for the service. Limit the use of codes indicating unspecified, not elsewhere classified or other specified diagnoses. In addition, signs and symptoms not associated routinely with a disease process should be coded when present.

It is more important than ever to include all diagnoses related to the service performed. There should be an obvious correlation between the diagnosis and the services provided. When this relationship is missing, claim denial could occur. It is also important to include any chronic conditions present at the time of the encounter. This will give a complete picture of the patient's health at the time of the service and helps reduce denials and requests for more information. ■

Access to Care

Select Health was pleased to share the results from our annual member satisfaction survey in the last issue. These results help show how well the plan and our providers are meeting members' expectations.

Results from the 2010 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey indicated members were pleased with their personal doctor and specialists. Members also gave "Doctor Communication" a very high rating—well above the 90th percentile as compared to other Medicaid health plans.

While these areas are meeting members' expectations, access to care was an area where the plan recognized opportunities for improvement. The 2010 overall composite results for 'Getting Care Quickly' of 77.4% demonstrated a decrease of 7.4% from 2009 results of 83.6%. The plan's 2010 results were also reported lower than the average for Medicaid health plans of 80.1%.

'Getting Care Quickly' is comprised of two questions:

- Obtaining needed care right away
- Obtaining care when needed, not when needed right away

In 2010, 75.4% of the members responded positively to obtaining needed care right away, indicating an 11.7% decline from the 2009 results. While results for "obtaining care when needed, not when needed right away" in 2010 were 79.4%—a 2.9% decline from the 2009 results.

The 2011 member satisfaction survey will begin in the first part of next year. Surveys are generally mailed out by the vendor by the end of January or first part February. We will be working with you in the following areas to help improve members' impression of their access to care.

- Review appointment availability standards and acceptable appointment wait time requirements.
- Increase the use of Navinet to access member care gaps.
- Continue to provide information on the plan's pharmacy authorization process.
- Continue to identify and recruit identified urgent care and free standing ancillary facilities. ■

To report suspected fraud and abuse, please contact the Corporate and Financial Investigations Unit Fraud Hotline at 866.833.9718 or the SCDHHS Fraud and Abuse Hotline at 888.364.3224.

Provider Services Contact Information	
Toll free	800.741.6605
Charleston	843.569.1759
Fax	843.569.0702
Website	www.selecthealthsc.com
Director, Network Management: Peggy Vickery	
Director, Provider Relations: Philip Fairchild	
Contract Management Representatives	
Lowcountry	Lisa Hart 843.569.4614
FeeDee	Paige Watford 843.933.0276
Midlands	Kay Steele 803.348.5792
Upstate	Pam Peterman 864.238.2041
Upstate	Terril Woodrome 864.787.8001

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