ProviderReport

peach state health plan™

Q&A: Credentialing rights

What happens during the credentialing and recredentialing process?
Peach State Health Plan obtains information from various outside sources, such as state licensing agencies and the National Practitioner Data Bank. Practitioners have the right to review primary source materials collected during this process.

How can I review these sources?
The information may be released to practitioners only after a written and signed request has been submitted to the Credentialing Department.

What if there is a discrepancy between these sources and the information I provide?
If any information gathered as part of the primary source verification process differs from data submitted by the practitioner on the credentialing application, Peach State Health Plan will notify the practitioner and request clarification.

How can I respond to any discrepancy?
A written explanation detailing the error or the difference in information must be submitted to Peach State Health Plan within 14 days of notification of the discrepancy in order to be included as part of the credentialing and recredentialing process.

How can I learn the status of my application?
Providers also have the right to request the status of their credentialing or recredentialing application any time by contacting the Credentialing Department at **1-800-766-4456** or by email at **PSHPproviderservices@centene.com**.

Hours of operation policies

Review your hours of operation policy to ensure that you are offering Medicaid members the same hours as commercial members, as required by the National Committee for Quality Assurance (NCQA).

Medicaid law requires that providers give equal offerings in terms of hours and appointments to Medicaid and non-Medicaid patients. If you are a provider that only sees Medicaid patients, you must provide parity of hours to Medicaid managed care members and Medicaid fee-for-service members.

Please note that NCQA will review provider contracts, manuals and marketing materials for any language that suggests hours of operation are different for Medicaid and non-Medicaid patients.

Help your patients, help our HEDIS scores

HEDIS, the Healthcare Effectiveness Data and Information Set, is a set of standardized performance measures updated and published annually by the National Committee for Quality Assurance (NCQA). HEDIS is a tool used by most of America's health plans to measure performance on important aspects of care and service. HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. Final HEDIS rates are typically reported to NCQA and state agencies once a year. Through HEDIS, NCQA holds Peach State Health Plan accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership. Peach State Health Plan also reviews HEDIS rates on an ongoing basis and continually looks for ways to improve our rates. It's an important part of our commitment to providing access to high-quality and appropriate care to our members.

Please consider the HEDIS topics covered in this issue of the provider newsletter: diabetes, hypertension and cardiac health. Also, review Peach State Health Plan's clinical practice guidelines at **pshp.com**.

HEDIS FOR DIABETES

The HEDIS measure for comprehensive diabetes care includes adult patients with Type I and Type II diabetes. There are multiple sub-measures included:

- HbA1c testing—completed at least annually. Both CPT codes 83036 and 83037 can be submitted when this test is completed.
- HbA1c level—
  - → HbA1c result > 9.0 = poor control
  - → HbA1c result < 8.0 = good control
  - → HbA1c result < 7.0 for selected population
- Blood pressure control— < 140/90
- Dilated retinal eye exam—annually, unless the exam the year prior was negative, then every two years
- Nephropathy screening test—macroalbumin or microalbumin urine test at least annually (unless documented evidence of nephropathy)

What providers can do

1. **Dilated retinal eye exam:** Peach State Health Plan can assist your office with finding a vision provider. Our vision vendor supports our efforts by contacting members in need of retinal eye exams to assist them in scheduling an appointment.
2. **Nephropathy screening test:** Did you know a spot urine dipstick for microalbumin or a random urine test for protein/creatinine ratio are two methods that meet the requirement for nephropathy screening?

HEDIS for heart care

The high blood pressure control HEDIS measure applies to patients who have been diagnosed with hypertension (excluding individuals with end-stage renal disease and pregnant women). The HEDIS measure evaluates the percentage of patients with hypertension with adequate control (defined as a systolic reading of less than 140 mm Hg and a diastolic reading of less than 90 mm Hg, or 140/90). For patients ages 60-85, adequate control is defined as less than 150/90.

The HEDIS measure for persistence of a beta-blocker treatment regimen after heart attack applies to patients who were hospitalized and discharged after an acute myocardial infarction (AMI). This measure calls for treatment with beta-blockers for six months after discharge. Patients with a known contraindication or a history of adverse reactions to beta-blocker therapy are excluded from the measure. Despite strong evidence of the effectiveness of drugs for cardiac problems, patient compliance remains a challenge.

What providers can do

- Continue to suggest and support lifestyle changes such as quitting smoking, losing excess weight, beginning an exercise program and improving nutrition.
- Stress the value of prescribed medications for managing heart disease. Peach State Health Plan can provide educational materials and other resources addressing the above topics.
- Please encourage your Peach State Health Plan patients to contact Peach State Health Plan for assistance in managing their medical condition. Peach State Health Plan case management staff members are available to assist with patients who have challenges adhering to prescribed medications or have difficulty filling their prescriptions. If you have a member you feel could benefit from our case management program, please contact Peach State Health Plan member services at **1-800-704-1484** and ask for medical case management.

New technology, new coverage

Peach State Health Plan evaluates the inclusion of new technology and new application of existing technology for coverage determination on an ongoing basis. We may provide coverage for new services or procedures that are deemed medically necessary. This may include medical and behavioral health procedures, pharmaceuticals or devices.

Requests for coverage will be reviewed and a determination made regarding any benefit changes that are indicated. When a request is made for new technology coverage on an individual case and a plan-wide coverage decision has not been made, Peach State Health Plan will review all information and make a determination on whether the request can be covered under the member's current benefits, based on medical necessity and the most recent scientific information available.

For more information, please call **1-866-874-0633**.

WE ARE HERE TO HELP

Contact us at **1-866-874-0633** to speak with our provider services team. Explore our site for tools and tips about utilization management, quality improvement, prior authorization and more.

To learn more about our provider services, please check our provider manual, available at **pshp.com**.

If you or one of our members would like a paper copy of anything found on our site, please call **1-866-874-0633**.

Review of denials

Peach State Health Plan sends you and your patients written notification any time a decision is made to deny, reduce, suspend or stop coverage of certain services. The denial notice includes information on the availability of a medical director to discuss the decision.

Peer-to-peer reviews

If a request for medical services is denied due to lack of medical necessity, a provider can request a peer-to-peer review with our medical director on the member's behalf. The medical director may be contacted by calling Peach State Health Plan at **1-866-874-0633**. A case manager may also coordinate communication between the medical director and the requesting practitioner as needed.

Filing appeals

The denial notice will also inform you and the member about how to file an appeal. In urgent cases, an expedited appeal is available and can be submitted verbally or in writing.

Please remember to always include sufficient clinical information when submitting prior authorization requests to allow for Peach State Health Plan to make timely medical necessity decisions based on complete information.

Member satisfaction survey results

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys ask consumers and patients to report on and evaluate their experiences with healthcare. Survey results are submitted to the National Committee for Quality Assurance (NCQA) to meet accreditation requirements. These surveys are completed annually and reflect how our members feel about the care they receive from our providers as well as the service they receive from the health plan. Peach State Health Plan will be using the results to help the plan improve.

We also want to share the results with you, since you and your staff are a key component of our members' satisfaction.

Here are some key findings from the survey:

Areas where we scored well include:

- Overall rating of the health plan rating scores by our child members
- Both our adult and child members scored us well on the survey in the area of how well doctors communicate.

Based on the feedback we received, some of the areas we have been working to improve include:

- Obtaining appointment with specialist as soon as needed
- Customer service

Peach State takes our members' concerns seriously and will work with you to improve their satisfaction in the future.

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