ProviderReport

buckeye health plan

How you can support HEDIS scores

The Healthcare Effectiveness Data and Information Set (HEDIS) provides a standardized method for managed care organizations to collect, calculate and report information about their performance. This allows employers, purchasers and consumers to compare different plans. Health plans use HEDIS results themselves to see where they need to focus their improvement efforts.

HEDIS has evolved over time and is now adapted to the Medicare and Medicaid managed care programs. It's a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and services.

HEDIS includes multiple measures divided into eight basic categories. Each category contains its own specific performance measures.

Below is a summary of key HEDIS measurements related to children's health. By promoting and following these guidelines, you can help us maintain strong HEDIS scores.

WELL-CHILD EXAMS

- **Ages 0 to 15 months:** Six well-care visits (at least 2 weeks apart) with a primary care provider (PCP), to include health and development history, physical exam and health education/anticipatory guidance.
- **Ages 3 to 6 years:** Annual well-care visits with a PCP, to include health and development history, physical exam and health education/anticipatory guidance.
- **Ages 12 to 21 years:** Annual well-care visits with a PCP or ob/gyn, to include health and development history, physical exam and health education/anticipatory guidance.

LEAD SCREENING

For children enrolled in Medicaid, federal law requires a blood lead level measured at 12 and 24 months of age. Children between the ages of 3 and 5 years of age must receive a blood lead test immediately if they have not been previously tested for lead poisoning.

DENTAL VISIT

Medicaid enrollees from ages 2 to 21 years should have at least one dental visit annually.

The appropriate use of resources

Buckeye Health Plan and its partners have utilization and claims management systems in place to identify, track and monitor care provided to our members. We want to ensure members have access to appropriate, quality care.

We do not reward practitioners, providers or employees who perform utilization reviews or issue denials of coverage or care. Utilization Management (UM) decision-making is based only on appropriateness of care, service and existence of coverage.

Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Denials are based on lack of medical necessity or lack of covered benefit.

Utilization review criteria have been developed to cover medical and surgical admissions, outpatient procedures, referrals to specialists and ancillary services. Buckeye Health Plan uses nationally recognized criteria (e.g. InterQual) if available for the specific service; other criteria are developed internally through a process that includes thorough review of scientific evidence and input from relevant specialists. Criteria are periodically evaluated and updated with appropriate involvement from physician members of our UM Committee.

Providers may obtain the criteria used to make a specific decision by contacting the Medical Management Department at **1-866-296-8731**. Practitioners also have the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer at the time of notification

LEARN MORE: Our UM staff is available Monday-Friday between 8 a.m. and 5 p.m. at **1-866-296-8731**.

Thank you for your feedback

Buckeye Health Plan recently conducted our annual Provider Satisfaction Survey. If you participated, thank you.

Survey questions covered a range of topics including provider relations, coordination of care, utilization, finance and overall satisfaction. Your feedback will guide our improvement efforts over the next year.

Specifically, we plan to focus on the following areas for improvement:

- Review opportunities to remove prior authorization requirement for selected Medicaid services.
- Develop processes to decrease the turnaround time frame for prior authorization requests.
- Develop provider tools and processes that will make the prior authorization process easier for the providers.

Behavioral health services for your patients

If you have patients who struggle with depression, anxiety, substance abuse or other behavioral health conditions, we have resources to help.

Buckeye Health Plan offers our members access to all covered, medically necessary behavioral health services. You can learn more about our behavioral health services at **www.cenpatico.com**.

For help identifying a behavioral health provider or for prior authorization for inpatient or outpatient services, call **1-866-296-8731**.

Make a difference: Cervical cancer among Hispanic women

According to the Centers for Disease Control and Prevention (CDC), Hispanic women in your practice have a higher chance of getting cervical cancer later in life than non-Hispanic women.

The HPV vaccine is an effective way to prevent many cases of cervical cancer, but only 57 percent of adolescent girls are getting the first dose. The CDC recommends medical providers give the HPV vaccine the same way and the same day the Tdap and meningococcal conjugate vaccines are given.

When you discuss the HPV vaccine with parents, confirm its value in preventing cancer. Parents may consider HPV a sexually transmitted disease and may believe their children don't need the vaccine if they aren't having sex. You can explain that HPV is so common that almost everyone in the U.S. will be infected by it at some point. So even if a child waits many years to have sex or only has one partner, there's a good chance he or she will be exposed.

Read more tips for discussing this important vaccine at **www.cdc.gov/vaccines/who/teens/for-hcp-tipsheet-hpv.pdf**.

The most up-to-date FORMULARY

The Pharmacy Department at Buckeye is charged with providing the most clinically sound and cost-effective drug therapy for our members. Due to ever-changing market conditions, there is an ongoing evaluation of therapeutic classes and new drugs that arrive on the market.

Our Pharmacy and Therapeutics Committee, whose membership includes community-based physicians, pharmacists and other practitioners, make decisions for changes to the Preferred Drug List (PDL). LEARN MORE: To get a printed copy of the most current PDL, which includes the procedures for prior authorization and other guidelines such as step therapy, quantity limits and exclusions, please call Provider Services at **1-866-296-8731**. You can also view the PDL online at **www.buckeyehealthplan.com/for-providers/pharmacy**.

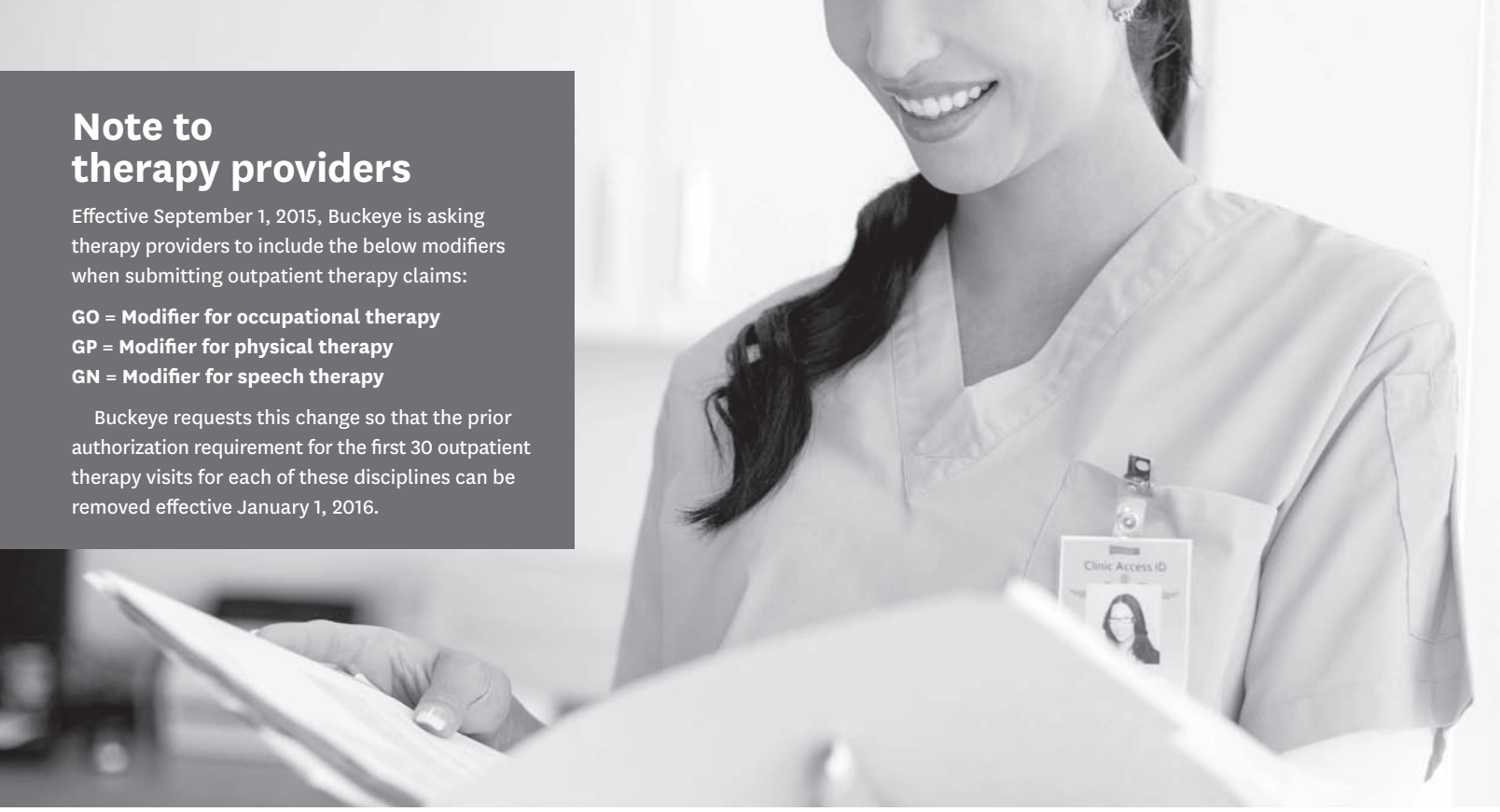
The Q4 update includes Nasacort OTC, Naratriptan, Rizatriptan, and Breo Ellipta. To see additional updates, visit the website above and click on PDL Quick Reference Guide.

Note to therapy providers

Effective September 1, 2015, Buckeye is asking therapy providers to include the below modifiers when submitting outpatient therapy claims:

GO = Modifier for occupational therapy
GP = Modifier for physical therapy
GN = Modifier for speech therapy

Buckeye requests this change so that the prior authorization requirement for the first 30 outpatient therapy visits for each of these disciplines can be removed effective January 1, 2016.



Medical record maintenance

Consistent and complete documentation in medical records is an essential part of quality care. We ask that participating practitioners keep uniform and organized medical records that contain member demographics and medical information regarding services rendered.

Medical records must be maintained in an organized system in compliance with our medical documentation and record-keeping standards. The intent with these standards is to help practitioners maintain complete medical records for all members, consistent with industry standards, and to meet state contract requirements.

A complete medical record must be maintained on each member for whom the practitioner has rendered healthcare services. These records must be protected from public access and any information released must comply with HIPAA guidelines.

Upon request, all participating practitioner medical records must be available for utilization review and QI studies—including HEDIS—as well as regulatory agency requests and member relations inquiries, as stated in the provider agreement.

Additionally, practitioners must provide a copy of a member's medical record upon reasonable request by the member at no charge.

The following is a list of the minimum required standards for practitioner medical record-keeping practices:

ORGANIZATION AND CONFIDENTIALITY

- Records are organized and stored in a manner that allows easy retrieval.
- Records are stored in a secure manner that allows access by authorized personnel only.
- Staff receive periodic training in member information confidentiality.

DEMOGRAPHIC CONTENT

Records should include:

- Patient identification information (patient name or identification number) on each written page or electronic file record
- Identity of the provider rendering the service

CLINICAL CONTENT

Records should include:

- All services provided directly by a practitioner who provides primary care services
- Date that the service was rendered
- All ancillary services and diagnostic tests ordered by the practitioner
- Explicit notations in the record for follow-up plans for abnormal lab and imaging study results; all entries should be initialed and dated by the ordering practitioner to signify review
- Documentation of all diagnostic and therapeutic services for which a member was referred to by a practitioner, including follow-up of outcomes and summaries of treatment rendered elsewhere such as: home health nursing reports, specialty physician reports, hospital discharge reports (emergency room and inpatient) and physical therapy reports
- History and physicals
- Allergies and adverse reactions (prominently documented in a uniform location)
- Problem list
- Medications
- Immunization records
- Documentation of clinical findings and evaluation for each visit (including appropriate treatment plan and follow-up schedule)
- Preventive services/risk screenings provided
- Documentation of health teaching, counseling and/or age appropriate anticipatory guidance
- Advance directives
- Documentation of failure to keep an appointment
- Documentation of physical health medical record information sent to behavioral health providers, if applicable
- Documentation of cultural, interpretation or linguistic needs; if not applicable, then documented as N/A

A shot at better health

Buckeye Health Plan requires all members under the age of 18 to be immunized by their doctor unless medically contraindicated or against the parents' religious beliefs.

Children must be immunized during medical checkups according to the current Advisory Committee for Immunization Practices (ACIP) Schedule. The most up-to-date recommendation for kids up to 18 years old can be found at **www.cdc.gov/vaccines/schedules**.

The CDC estimates that the vaccination of kids born between 1994 and 2013 will prevent 322 million illnesses and 732,000 deaths.

AUTHORIZATION REMINDER

To help us process authorization requests accurately and efficiently, please submit sufficient medical information to justify the request. If you have questions or concerns about the type of medical information required, contact our Medical Management Department at **1-866-296-8731**.

Prepare **new parents**

The first few months of a baby's life can feel overwhelming to mom and dad. You can help them keep immunizations on their to-do list.

Prepare new parents for the schedule of shots and offer them the following chart:

IMMUNIZATION CHART				
BIRTH	**1 MONTH**	**2 MONTHS**	**4 MONTHS**	**6 MONTHS**
HepB	····· HepB ·····			HepB
		RV	RV	RV
		DTaP	DTaP	DTaP
		Hib	Hib	Hib
		PCV	PCV	PCV
		IPV	IPV	IPV
				Influenza

VACCINE	DISEASE(S)	VACCINE	DISEASE(S)	VACCINE	DISEASE(S)
HepB	Hepatitis B	DTaP	Diphtheria, tetanus, pertussis	PCV	Pneumococcus
RV	Rotavirus	Hib	*Haemophilus influenzae* type b	IPV	Polio

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buckeye health plan Advantage

Information regarding Buckeye's 2015 Quality Improvement Program Description is available for review upon request.

MEMBER SERVICES: 1-866-246-4358

PROVIDER SERVICES: 1-866-296-8731

To receive a paper copy of any information referenced in this newsletter or on the Buckeye website, please call Buckeye's Provider Services.