NewsFlash

mhs health wisconsin

Review of denials

Anytime we make a decision to deny, reduce, suspend or stop coverage of certain services, MHS Health Wisconsin will send you and your patient written notification. 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 a 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 MHS Health Wisconsin at **1-800-547-1647**. 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 our member about how to file an appeal. In urgent cases, an expedited appeal is available and can be submitted orally or in writing.

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

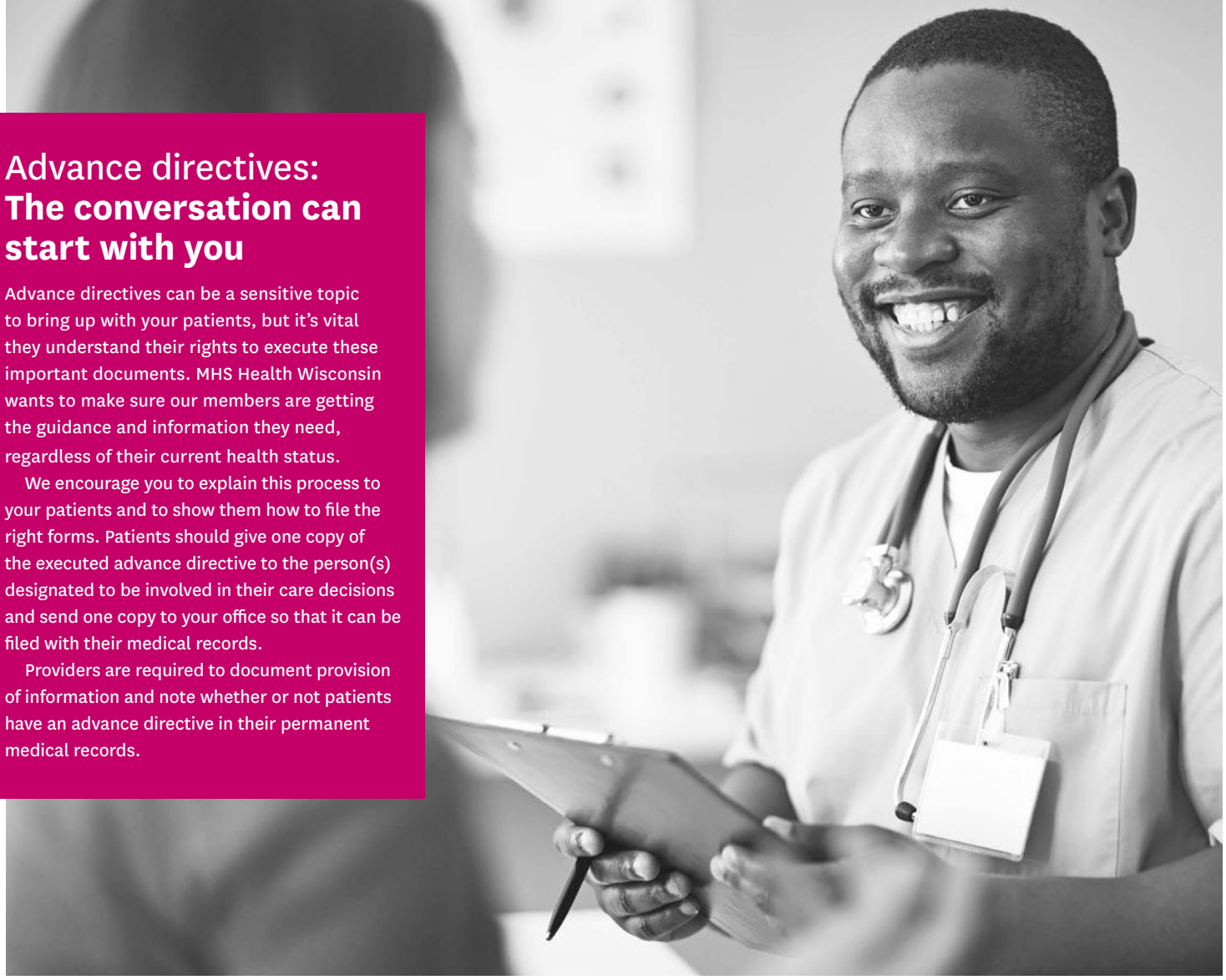
REMINDER: Don't delay on credentialing

During the credentialing and recredentialing process, MHS Health Wisconsin 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. If any information gathered as part of the primary source verification process differs from data submitted by the practitioner on the credentialing application, MHS Health Wisconsin will notify the practitioner and request clarification.

A written explanation detailing the error or the difference in information must be submitted to MHS Health Wisconsin in order to be included as part of the credentialing and recredentialing process. It's important that we receive this information in a timely manner to avoid delays in credentialing decisions.

Providers also have the right to request the status of their credentialing or recredentialing application at any time by contacting Provider Services at **1-800-222-9831** or by email at **MHS-WIPDM@mhswi.com**.



Advance directives: **The conversation can start with you**

Advance directives can be a sensitive topic to bring up with your patients, but it's vital they understand their rights to execute these important documents. MHS Health Wisconsin wants to make sure our members are getting the guidance and information they need, regardless of their current health status.

We encourage you to explain this process to your patients and to show them how to file the right forms. Patients should give one copy of the executed advance directive to the person(s) designated to be involved in their care decisions and send one copy to your office so that it can be filed with their medical records.

Providers are required to document provision of information and note whether or not patients have an advance directive in their permanent medical records.

Inform your patients: The National Hospice and Palliative Care Organization has compiled key information about advance directives in a question-and-answer format: **www.caringinfo.org/files/public/brochures/Understanding_Advance_Directives.pdf**. Patients can find state-specific advance directives here: **www.caringinfo.org/i4a/pages/index.cfm?pageid=3289**.

What our **members are saying**

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 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. MHS Health Wisconsin will be using the results to guide our improvement efforts.

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

Here are some key findings from the survey. Areas where we scored well include:

- How well physicians communicate
- Getting needed care quickly
- Getting needed care

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

- Rating of a personal physician
- Customer service
- Shared decision-making

MHS Health Wisconsin takes our members' concerns seriously and will work with you to improve members' satisfaction in the future.

Let us know your plans

Our goal is to provide seamless care for our members. To support this goal, it's important that we know if you're planning to move, change phone numbers or leave the network.

To ensure that your contact information and status are up to date, visit our secure provider portal at **www.mhswi.com** or call **1-800-222-9831**. Please let us know at least 30 days before you expect a change to your information.

Why **HEDIS matters**

HEDIS, the Healthcare Effectiveness Data and Information Set, is a list 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 healthcare plans. Final HEDIS rates are typically reported to NCQA and state agencies once a year.

Through HEDIS, NCQA holds MHS Health Wisconsin accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership. MHS Health also reviews HEDIS rates on an ongoing basis and continually looks for ways to improve those 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: diabetes, high blood pressure and engagement in treatment of substance abuse. Also, review MHS Health's clinical practice guidelines at **www.mhswi.com** and encourage your MHS Health members to contact MHS Health for help managing their medical condition. MHS Health case management staff members are available to assist with patients who have difficulty managing their conditions, challenges adhering to prescribed medications or difficulty filling their prescriptions. If you have a member you feel could benefit from our case management program, please contact MHS Health Member Services at **1-888-713-6180** and ask for medical case management.

HEDIS FOR DIABETES CARE

The HEDIS measure for comprehensive diabetes care is directed to adult patients ages 18 to 75 who have type I or type II diabetes.

- **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 (CPT II code 3046F)
  - → HbA1c result < 8.0 = in control (CPT II code 3045F)
- **Dilated retinal eye exam:** Exam in previous two years
- **Medical care for nephropathy:** At least one of the following: nephropathy screening, ACE/ARB therapy or documented evidence of nephropathy
- **Blood pressure:** < 140/90 mm Hg considered in control

What providers can do

1. **Dilated retinal eye exam:** MHS Health Wisconsin can assist your office with finding a vision provider. Our vision vendors support our efforts by contacting members in need of retinal eye exams to assist them in scheduling an appointment.
2. **Nephropathy screening test:** 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. You may offer either to your patients.

HEDIS for **high blood pressure**

The medical costs of high blood pressure total more than $46 billion annually. This number could increase to $274 billion by 2030. Approximately one in three U.S. adults, or about 70 million people, has high blood pressure, but only about half of these people have it under control.

The high blood pressure control HEDIS measure applies to the percentage of adults 18 to 85 years old who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. Adequate control is defined by the following criteria:

- Adults 18–59 years of age whose blood pressure was less than 140/90 mm Hg
- Adults 60–85 years of age, with a diagnosis of diabetes, whose blood pressure was less than 140/90 mm Hg
- Adults 60–85 years of age, without a diagnosis of diabetes, whose blood pressure was less than 150/90 mm Hg

Exclusions apply if there is evidence of the following during the measurement year:

- End-stage renal disease
- Kidney transplant or dialysis
- Pregnancy
- Non-acute inpatient admission

What providers can do

1. **Teach patients how lifestyle changes can control high blood pressure:** Encourage low-sodium diets, increased physical activity and smoking cessation.
2. **Prescribe and follow up on blood pressure medication:** Patients may assume that because they "feel good," they may stop filling their prescription. Confirm that they understand the importance of keeping up with these prescriptions.

HEDIS for engagement in **treatment of substance use**

The HEDIS measure to address the utilization of substances is the initiation and engagement of alcohol and other drug dependence treatment (IET). This applies to individuals who are newly diagnosed with a substance use disorder and who attend treatment during the following time frames:

- **Initiation of AOD (alcohol and other drug) treatment:** The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis
- **Engagement of AOD treatment:** The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

The IET HEDIS measure applies to individuals 13 years and older, with a new episode of alcohol and other drug abuse (AODA) who had one of the following:

- An outpatient, intensive outpatient or partial hospitalization visit with a diagnosis of AODA
- A detoxification visit with diagnosis of AODA
- An emergency department visit with diagnosis of AODA
- An inpatient discharge with a diagnosis of AODA
- A negative diagnosis history (AODA within 60 days)

What providers can do

1. **Screen for it!** Please incorporate substance use questions or tools upon intake and upon yearly treatment plan review, at a minimum.
2. **Follow up!** When substance abuse is identified, it's very important to schedule appropriate follow-up treatment. For newly diagnosed members, we ask that you schedule two follow-up appointments within the first 30 days.
3. **Document it!** If substance abuse is identified, be sure to document it and code it on any claims submitted. When substance abuse is no longer a diagnosis, be sure to remove the code from any claims submitted.
4. **Educate!** It's important to educate members on the effects of substance abuse. Substance abuse often coincides with other behavioral health problems, like major depression or anxiety disorders, which can make treating substance abuse or diagnosing a behavioral health disorder more difficult. In instances like these, referral to a behavioral health provider is prudent.

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