REDUCING READMISSIONS

Readmissions are often linked to the quality of care received during an initial hospital stay, but readmissions can also occur when members don’t receive appropriate follow-up care. One in three adult patients, aged 21 and older, do not see a physician within 30 days of discharge from the hospital.¹

Follow-up care from a physician or other medical provider after a hospital discharge is important to monitor the condition that led to the hospitalization, and to minimize readmissions.

Missouri Care is committed to improving the coordination of care between not only the members and providers, but also across medical settings. Ensuring that adequate follow-up is being conducted may help to decrease the number of members who require a hospital readmission.

The Hospital Patient Safety Survey is an example of how Missouri Care evaluates coordination of care between hospitals and PCPs. The survey’s intent is to understand hospitals’ discharge processes. After evaluating the results, Missouri Care found that most hospitals surveyed have a process to identify members’ PCPs prior to being discharged, but follow-up appointments are not always being scheduled for members. The survey found that 72.7% of the time, follow-up appointments are scheduled by the hospital when a member is discharged during normal business hours. However, only 27.3% of the time, follow-up appointments are scheduled by the hospital when members are discharged outside of normal business hours.

An important step for members to have positive health outcomes is to ensure that they have follow-up appointments after a hospital discharge.

Source: ¹ www.nihcr.org/news_reducing_readmissions
APPEALS TIPS

Missouri Care strives for timely appeal resolution, and offers the following tips to help our provider partners with this process:

Tip 1: Missouri Care cannot process an appeal without a cover letter clearly stating the reason for the appeal.

Tip 2: Make sure your appeal cover letter addresses the actual reason your claim was denied. For example, if your claim was denied due to the fact that you failed to get prior authorization, you need to explain extenuating circumstances as to why you failed to get prior authorization. If you simply say that the treatment was medically necessary and the claim was not denied due to medical necessity, the denial will be upheld.

Tip 3: In order to avoid delays in processing, be sure you are sending appeals and disputes to the correct addresses (see provider manual for the definition of a dispute versus an appeal).

- Send all appeals to Missouri Care, Attn: Appeals, 2404 Forum Blvd., Columbia, MO 65203
- Send all disputes to Missouri Care, Attn: Claim Payment Disputes, P.O. Box 31370, Tampa, FL 33631-3370

DISEASE MANAGEMENT – IMPROVING MEMBERS’ HEALTH

Disease management is a free, voluntary program to assist members with specific chronic conditions. These members are assigned a disease nurse manager who can help them with:

- Education and understanding of his or her specific condition
- Identification of adherence barriers and ways to overcome them
- Individualized lifestyle modification suggestions to improve daily life
- Self-management of the member’s condition to improve health outcomes
- Motivational coaching for encouragement with member struggles along the way
- Improved communication with the member’s primary care provider (PCP) and health care team

Disease management can assist your members with the following conditions:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- Hypertension
- Obesity
- Smoking cessation
- Depression

For more information, or to refer a member to Disease Management, please refer to your Quick Reference Guide at www.missouricare.com/provider/resources

HOW CASE MANAGEMENT CAN HELP YOU

Case Management helps members with special needs. It pairs a member with a case manager. The case manager is a registered nurse (RN) or licensed clinical social worker (LCSW) who can help the member with issues such as:

- Complex medical and behavioral health needs
- Lead poisoning
- Maternity needs
- Solid organ and tissue transplants
- Chronic illnesses such as asthma, diabetes, hypertension and heart disease
- Children with special health care needs
- Improved communication with the member’s primary care provider (PCP) and health care team

We’re here to help you! For more information about Case Management, or to refer a member to the program, please call us at 1-800-322-6027. This no-cost program gives access to a registered nurse or licensed clinical social worker Monday–Friday from 8 a.m. to 5 p.m.
**2015 CAHPS SURVEY**

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is designed to collect important information from patients about the care they receive from their doctors and health plans. The survey was mailed to members in early March 2015.

Members (your patients) were asked to rate their experiences with getting needed care, getting appointments and care quickly, how well their doctor communicates, the coordination of their care and their overall rating of the health care they received. Please consider how patients perceive your practice and the care they receive. Our goal is to partner with you to help your patients get the best health care possible. We want to work with you to achieve this.

The following suggestions are based on feedback from your colleagues on how to improve patient experience ratings:

- Let patients know your office hours and how to get care after hours.
- Offer to schedule specialist appointments while your patients are in the office.
- Make sure your contact information is correct in the Missouri Care directory.
- Offer extended, evening or weekend hours.
- If you are running late, have your staff let your patients know and apologize.
- Consider offering email or text communication, particularly for medication refills.
- Remember, almost everyone can receive and benefit from a flu shot.
- It’s just as important to explain why you are not doing something as it is to explain what you are doing.
- Invite questions and encourage your patients to make notes – research shows most patients forget two out of three things you tell them when they walk out of the exam room.

Remember: People don’t care how much you know until they know how much you care!

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

**EMERGENCY DEPARTMENT SUPER UTILIZER PROGRAM**

In conjunction with the National Governors Association, Missouri Care promotes both efficient and effective Emergency Department (ED) management. We share the goals of all providers, to improve health care access and outcomes for the people we serve.

- Missouri Care offers intensive care management for patients with multiple ED visits. This effectively decreases the burden of non-emergent patients seen in the ED.
- Our case managers can assist your patients’ access to community resources such as shelters, utilities, transportation and support groups.
- Case Management improves member adherence with the primary care provider’s treatment plan and improves quality outcomes.
- Case managers are able to assist with substance abuse disorders and behavioral health issues. Please refer your patients for these services if needed.
- Missouri Care’s Provider Relations representatives are able to assist providers who identify patients with excessive ED utilization. Lists of provider-specific super utilizers are available upon request.
- You may call our Member Engagement Unit, 1-866-635-7045, to refer a patient to our care management program.
- The demographic information we receive is at times inaccurate. Your trusting relationship with your patients often allows you to obtain this information. Please share this with our case managers to optimize collaborative efforts.
- Providers are most able to identify which patients need additional social support and assistance, especially for those members who initially decline case management services. Please discuss this valuable option with your patients.
- As an added service, members may call our 24-hour nurse line at 1-800-919-8807 to answer any concerns. This service often helps to direct your patient to your office.
- Please remind your patients about the availability of weekend and evening clinics, urgent care centers and covering physicians when the patient’s doctor is not available.
**UPDATING PROVIDER DIRECTORY INFORMATION**

We rely on our provider network to advise us of demographic changes so we can keep our information current.

To ensure our members and Case Management staff have up-to-date provider information, please send us written, advance notice of changes you make to your office phone number, office address or panel status (open/closed). Thirty-day advance notice is recommended.

**New Phone Number, Office Address or Change in Panel Status** – Send a letter on your letterhead with the information being updated. Please include contact information if we need to follow up on the update with you.

Please send the letter by any of these methods:

- **Email:** MissouriProviderRelations@wellcare.com
- **Fax:** 1-866-946-1105
- **Mail:** Missouri Care, Attention: Provider Operations, 2404 Forum Blvd, Columbia, MO 65203

Thank you for helping us maintain up-to-date directory information for your practice.

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**BEHAVIORAL HEALTH HEDIS MEASURES**

Did you know there are HEDIS® measures related to behavioral health?

Below outlines some of the behavioral health HEDIS measures.

**ANTIDEPRESSANT MEDICATION MANAGEMENT**

The percentage of members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment.

**FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION**

The percentage of members 6–12 years of age newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days and 30 days of discharge.

**ADOLESCENT WELL-CARE VISITS**

All adolescents should get at least one comprehensive well-care checkup with a PCP or an OB/GYN every year. Healthy Children and Youth/Early and Periodic Screening, Diagnosis and Treatment (HCY/EPSDT) screening forms and guidelines offer education to providers about the health care services that are available to prevent and treat illnesses for Medicaid members. In addition to improving members’ health, an annual checkup provides adolescents an opportunity to develop attitudes and lifestyles that can enhance health and well-being.

According to HEDIS, the following must occur and be documented in the medical record for a member to be compliant for an adolescent well-care exam:

- A health history
- A mental developmental history
- A physical developmental history
- A physical exam
- Health education/anticipatory guidance

Keep in mind, a sick-child visit or sports physical can be an opportunity to complete a comprehensive well-care exam.

Providers should document all well-child visits using the State’s HCY screening forms at:

manuscripts.momed.com/manuals/presentation/forms.jsp
CLAIMS PAYMENT POLICY REMINDERS

Timely claims payments are important to Missouri Care and our partner providers. In order to ensure this timeliness, we have identified some areas for improvement in claims submissions.

MODIFIER 25

All E&M services provided on the same day as a procedure are part of the procedure, and Missouri Care only makes separate payment if an exception applies.

Modifier 25 is used to describe a significant, separately identifiable E&M service that was performed at the same time as a procedure.

The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have documented that Modifier 25 is one of the most frequently misused modifiers by medical providers. Missouri Care may require medical records prior to payment for E&M services to which Modifier 25 is appended in certain situations to validate that the documentation demonstrates that the E&M service is significant and separately identifiable.

A member’s medical documentation must clearly show that the E&M service that was performed and billed was unique and distinct from the usual preoperative and postoperative care associated with the primary procedure performed on the date of service.

Providers should reference the NCCI Policy Manual for guidance on correct submission of Modifier 25.

PLACE OF SERVICE CODING

According to CMS policy, the place of service code (POS) used should indicate the setting in which the patient received a face-to-face encounter or where the technical component of a service was rendered, in the case of an interpretation. However, when a patient is in a registered inpatient status, all services billed by all providers should reflect and acknowledge the patient’s inpatient status.

When a physician/provider/supplier furnishes services to a registered inpatient, payment is made under the physician fee schedule at the facility rate. A physician/provider/supplier furnishing services to a patient who is a registered inpatient shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter, according to the Missouri Care policy.

Providers should reference MLN Matters MM7631 for place of service coding instruction.

LOCAL COVERAGE DETERMINATIONS

Unless a more restrictive Missouri Care Clinical Coverage Determination exists, Missouri Care relies on guidance published in Local Coverage Determinations (LCDs), respective to the state in which the service is rendered, to determine coverage requirements.
ENCOURAGE CHLAMYDIA SCREENINGS

*Chlamydia trachomatis* (Chlamydia) is one of the most common sexually transmitted bacterial infections in the U.S. and causes numerous health problems in both women and men.

Most women infected with Chlamydia have no symptoms of the disease, thereby minimizing the chances they will seek care. Because of the negative impact Chlamydia can have on members’ health it is imperative that the member obtains a Chlamydia test as recommended.

To help protect and improve members’ health, Missouri Care will encourage and recommend PCPs to screen annually for Chlamydia in all female members 16-24 years of age who indicate they are sexually active.

Below are some billing codes:

<table>
<thead>
<tr>
<th>CPT Codes / HCPCS Codes / ICD-9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT codes covered if selection criteria are met (not covered for screening of asymptomatic men):</td>
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<tr>
<td>87110</td>
</tr>
<tr>
<td>87490</td>
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<tr>
<td>87810</td>
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</table>

<table>
<thead>
<tr>
<th>ICD-9 codes covered if selection criteria are met:</th>
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</thead>
<tbody>
<tr>
<td>628.0 - 628.9</td>
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<tr>
<td>V02.8</td>
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<tr>
<td>V26.21</td>
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<td>V73.88</td>
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<tr>
<td>V73.98</td>
</tr>
<tr>
<td>V74.5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other ICD-9 codes related to the CPB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>099.41</td>
</tr>
<tr>
<td>099.50 - 099.56</td>
</tr>
</tbody>
</table>

Sources: [www.cdc.gov/std/stats12/chlamydia.htm](http://www.cdc.gov/std/stats12/chlamydia.htm)  

CHANGES TO NEWBORN DELIVERY COVERAGE AND CLAIM REQUIREMENTS

Effective June 1, 2015, Missouri Care will implement the changes described in Missouri Health Net’s Provider Bulletin Volume 37 Number 07 regarding Early Elective Deliveries.

Key points with regard to the June 1, 2015, changes include:

- Missouri Care will no longer reimburse services for deliveries prior to 39 weeks gestational age that are not medically indicated.
- Non-payment will include both services billed by the delivering physician/providers and the delivering institution.
- Professional claims for delivery charges must include an additional required field to report the gestational age and delivery indicator.

Please refer to the Missouri Health Net Bulletin for more detailed information about the changes.
**BETTER QUALITY IS OUR GOAL**

Missouri Care’s Quality Improvement (QI) program is an ongoing, comprehensive and integrated system that exists to actively initiate, monitor and evaluate standards of health care practice and infrastructures essential to the delivery of quality clinical care and service to members.

**SOME 2014 QI PROGRAM GOALS WE ACCOMPLISHED INCLUDE:**

- Developed new incentive programs which reward members and providers when members receive preventive screenings and wellness visits
- Responded to reported quality concerns
- Encouraged members to go to well visits, including mammograms, eye exams for those with diabetes, prenatal and postpartum visits, well-child checkups, immunizations and more
- Reminded providers about members who may be missing care services
- Met members language, cultural and ethnic needs
- Made sure members could reach providers by phone, get a timely appointment and find a provider near their home
- Made sure Missouri Care answered calls quickly
- Ensured claims were paid accurately
- Improved members’ health care through Case Management and Disease Management
- Encouraged coordination of care between providers and specialists
- Provided information about Missouri Care’s services at community events

**OUR GOALS FOR 2015 INCLUDE:**

- Expand our incentive program to reward members for healthy behaviors and encourage providers to close care gaps
- Work with providers and community agencies to improve care for our members
- Continue to measure the quality of the care and services members receive
- Continue working with members and providers, such as distributing care gap reports and Provider HEDIS Toolkits. Together, we can meet members’ health care needs
- Coordinate members’ health care. This improves the quality of care
- Continue to ask if members are satisfied. This helps us make sure members are pleased with Missouri Care and their providers
- Ask what providers think of our service. We’ll use this feedback to improve our services
- Review and update our guidelines. This will help us keep a safe and healthy environment
- Improve members’ health care through Case Management and Disease Management
- Monitor members’ care through medical record review

We look forward to continuing to partner with you to ensure our members get the best care. For more information about the QI Program, please contact your Provider Relations representative or call 1-800-322-6027.

**PROVIDER TERMINATION NOTIFICATION**

Missouri Care is required to provide our members with timely notification when a provider is no longer available on our plan. To assure that members have a full 30-day notice of a provider’s termination, we send out member notifications 45 days prior to a provider’s actual termination date.

For this reason, we require our contracted providers to give 90 days prior written notice to Missouri Care if they will be leaving the Missouri Care network. This will allow enough lead time for us to update our system and to ensure we meet our member advance notice requirement.
PROVIDER RESOURCES

WEB RESOURCES
Visit www.missouricare.com to access our Preventive and Clinical Practice Guidelines, Clinical Coverage Guidelines, Pharmacy Guidelines, key forms and other helpful resources. You may also request hard copies of any of the above documents by contacting your Provider Relations representative. For additional information, please refer to your Quick Reference Guide at www.missouricare.com/provider/resources.

PROVIDER NEWS
Remember to check messages regularly to receive new and updated information. Visit the secure area of www.missouricare.com to find copies of the latest correspondence. Access the secure portal using the “Member/Provider Secure Sign-In” area on the right. You will see Messages from WellCare located in the right hand column.

ADDITIONAL CRITERIA AVAILABLE
Please remember that all Clinical Coverage Guidelines, detailing medical necessity criteria for several medical procedures, devices and tests are available on our website at www.wellcare.com/provider/ccgs.