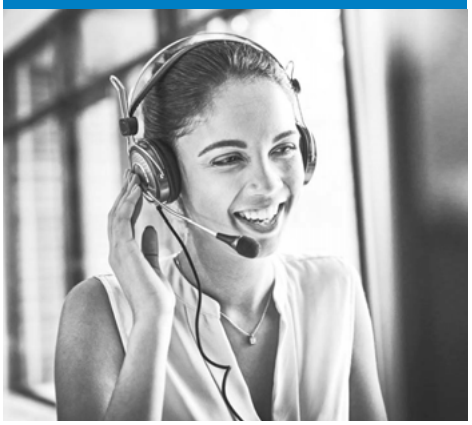
ProviderReport

MARYLAND physicians care
MANAGED CARE ORGANIZATION

Keep us informed

Maryland Physicians Care wants to provide the best care we can to our members. That means it's important for us to know if you plan to move, change phone numbers or leave the network. Call **1-800-953-8854** to update or verify your contact information or status. You can also check your information on our secure provider portal at **MarylandPhysiciansCare.com**.

Please let us know at least 30 days before you expect a change to your information.



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When a service **is denied**

Any time Maryland Physicians Care decides to deny, reduce, suspend or stop coverage of certain services, we will send you and your patient written notification. The denial notice will include information on the availability of a medical director to discuss the decision.

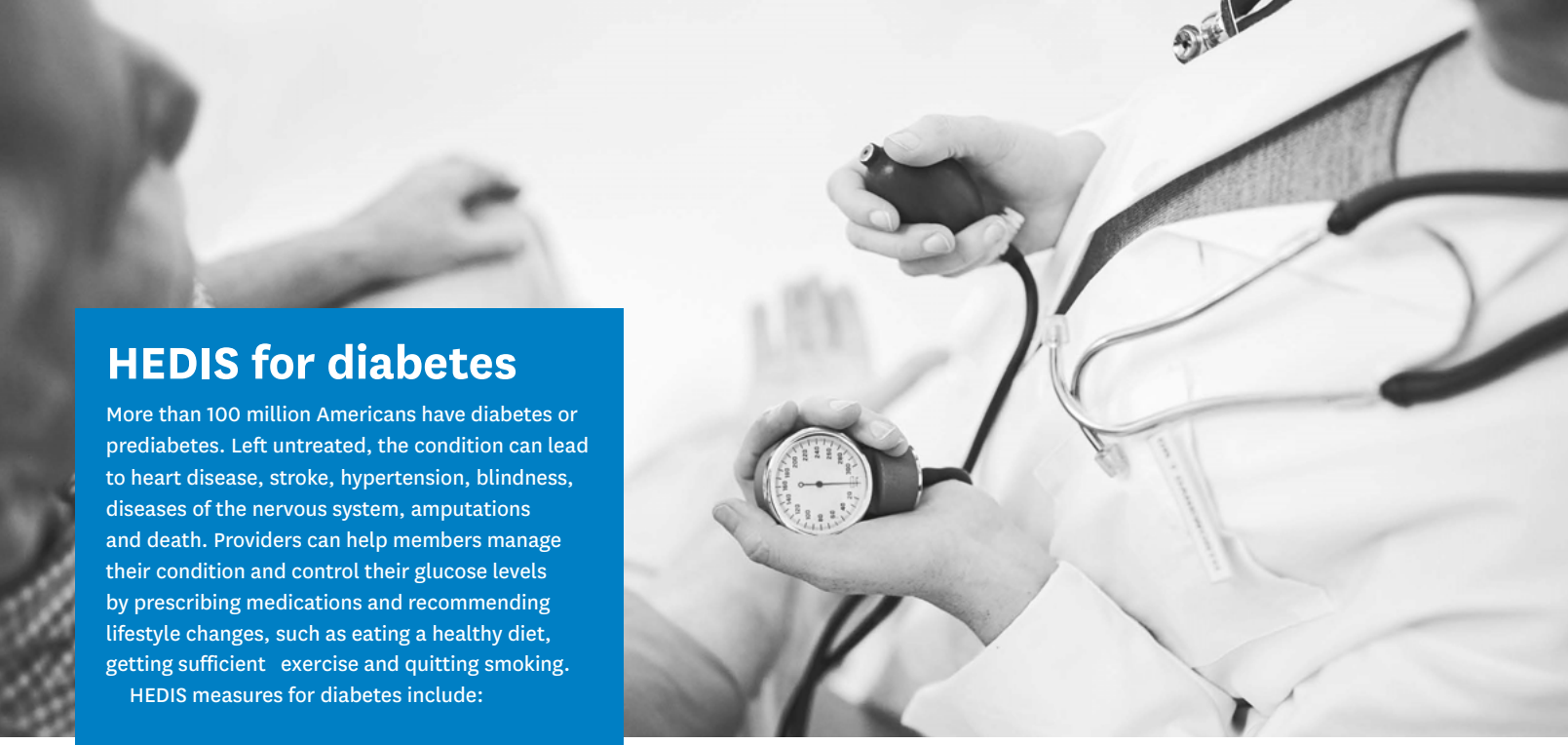
Peer-to-Peer Reviews

If a request for medical services is denied because of 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 Maryland Physicians Care at **1-800-953-8854**. A care 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 verbally or in writing.

Please remember to always include sufficient clinical information when submitting prior authorization requests to allow Maryland Physicians Care to make timely medical necessity decisions based on complete information.



HEDIS for diabetes

More than 100 million Americans have diabetes or prediabetes. Left untreated, the condition can lead to heart disease, stroke, hypertension, blindness, diseases of the nervous system, amputations and death. Providers can help members manage their condition and control their glucose levels by prescribing medications and recommending lifestyle changes, such as eating a healthy diet, getting sufficient exercise and quitting smoking.

HEDIS measures for diabetes include:

- Comprehensive diabetes care
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
- Diabetes monitoring for people with diabetes and schizophrenia
- Statin therapy for patients with diabetes

NCQA provides a Diabetes Recognition Program to recognize providers who use HEDIS measures to care for their patients with diabetes. To learn more about the program, go to the **NCQA website**.

Tests for diabetics

The HEDIS measure for comprehensive diabetes care, directed to patients ages 18 to 75 who have Type 1 or Type 2 diabetes, lists the following tests and exams:

- **HbA1c testing.** Completed at least annually
  - HbA1c result > 9 = poor control
  - HbA1c result < 8 = in control
- **Dilated retinal eye exam.** Performed 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.** Lower than 140/90 mm Hg considered in control

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HEDIS measures performance

HEDIS, the Healthcare Effecti eness 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 U.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 healthcare plans. Final HEDIS rates are typically reported to NCQA, the Centers for Medicare & Medicaid Services, and state agencies once a year. Through HEDIS, NCQA holds Maryland Physicians Care accountable for the timeliness and quality of healthcare services (e.g., acute, preventive and mental health) delivered to its diverse membership. Maryland Physicians Care also continually reviews HEDIS rates and looks for ways to improve.

HEDIS topics covered in this issue of the provider newsletter include diabetes, hypertension and metabolic monitoring for children and adolescents on antipsychotics.

HEDIS for hypertension

The HEDIS measure for controlling high blood pressure is designed to assess how well adults with hypertension are managing their condition, as uncontrolled high blood pressure can lead to heart attacks, stroke and kidney disease.

NCQA recently updated the measure to reflect a new blood pressure target: below 140/90 mm Hg for adults ages 18 to 85 with a diagnosis of hypertension. The previous measure included a diffe ent target for older adults without diabetes.

In addition to updating the measure, NCQA will allow:

- More administrative methods to collect the measure
- Blood pressure readings to be taken using remote patient monitoring devices
- Telehealth encounters to satisfy certain components of the measure

To learn more about revisions to the high blood pressure measure, review the **2019 summary of HEDIS changes**.

What's new in HEDIS?

Each year, NCQA releases new technical specifications for HEDIS measures. The 2019 changes include:

NEW MEASURES

- **Risk of continued opioid use.** This measure assesses the percentage of members ages 18 and older who have a new episode of opioid use that puts them at risk of continued use.
- **Prenatal immunization status.** This addition assesses the percentage of deliveries at 37 gestational weeks or more in which women received influenza and diphtheria and pertussis (Tdap) vaccines.
- **Adult immunization status.** This measure tracks the percentage of adults ages 19 and older who are up to date on vaccines for influenza, tetanus and diphtheria (Td) or tetanus, Tdap, herpes zoster and pneumococcal disease.

CHANGES TO EXISTING MEASURES

- **Controlling high blood pressure.** The measure was updated to align with clinical guidelines. Read more in the article on Page 2.
- **Follow-up after emergency department visit for mental illness.** Patients going to the emergency room with intentional self-inflic ed injuries may receive a principal diagnosis for the injury and a secondary diagnosis for mental illness. Because of this, NCQA added a principal diagnosis of intentional self-harm to the denominator and a principal diagnosis of intentional self-harm with a secondary diagnosis of a mental health disorder to the numerator.
- **Follow-up after hospitalization for mental illness.** NCQA added a principal diagnosis of intentional self-harm to the denominator.
- **Plan all-cause readmissions.** This measure will now include observation stays as index hospitalizations and readmissions events for all product lines. It will also remove patients with high-frequency hospitalization from the risk-adjusted readmission rate and report a rate of these outlying individuals among the plan population. Implementation of this measure is delayed until 2020.

CROSS-CUTTING TOPICS

NCQA instituted two changes across multiple measures. These are the introduction of telehealth into 14 measures and the exclusion of members with advanced illness from certain **measures**, including cancer screenings and some cardiovascular measures.

Monitoring youths on antipsychotic medications

Children and adolescents who are prescribed antipsychotic medications are at increased risk of weight gain, high blood sugar, high cholesterol and triglyceride levels and elevated blood pressure. If three or more of these occur at the same time, it is called metabolic syndrome.

The HEDIS measure for metabolic monitoring for children and adolescents on antipsychotics assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year.

Providers can help members by continually monitoring factors such as blood sugar and weight and by advising children and adolescents to be physically active and eat a healthy diet.

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Communication: A vital part of coordinated care

Your goal is to provide the highest quality of care for each patient. As a specialist, sharing information with each patient's primary care provider (PCP) is essential. That communication provides continuity and helps to ensure the best possible outcome for the patient.

Still, in the rapidly evolving world of medicine, communication isn't always easy. More and more patients have multiple chronic conditions. They may be seen by one or more specialists in addition to their PCP.

As a result, care must be thoughtfully coordinated, with good communication between specialists and PCPs. Otherwise care may become fragmented, and crucial details can slip through the cracks.

Specialty care providers should take steps to ensure that patients' information is shared with their PCP in a timely manner.

Start with these two basic steps:

1. Request that the lab copy the PCP when sending test results.
2. Send the results to the PCP directly.

Good communication helps things run smoothly, which can lead to healthier, happier patients.

Concurrent review process

Services that require concurrent review include, but are not limited to, those provided in acute facilities, rehabilitation facilities and skilled nursing facilities.

Notification of admission to an acute hospital must be made within one business day of the admission. Clinical information to support the inpatient admission must be submitted within 24 hours of the notification. Concurrent review nurses utilize InterQual guidelines to review for medical necessity.

If this information meets guidelines, then the request can be processed. All requests that do not appear to meet InterQual guidelines are referred to a second review by the medical director. Please refer to our website for further information at **MarylandPhysiciansCare.com**.

Prior authorization request process

The MPC website has a Pre-Authorization Check tool to assist in determining if your requested service requires prior authorization. In addition, any request for elective inpatient admission and all nonparticipating providers must also obtain prior authorization before rendering any service other than emergency and self-referral services.

Both InterQual guidelines and Centene Clinical Policies are used to evaluate each request. Per COMAR, the state-mandated turnaround time is two business days when all the appropriate clinical information has been received. If the request is not submitted with the appropriate clinical information, the state-mandated turnaround time is increased to 14 calendar days.

If the submitted information meets guidelines, then the request can be processed. All requests that do not appear to meet the guidelines are referred to a second review by the medical director. When a request is not authorized, the rationale for the denial is sent to the requesting provider as well as the member. Please refer to the denial letter for the peer-to-peer and appeals processes. Please visit our website at **MarylandPhysiciansCare.com.**

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Your credentialing rights

Credentialing protects our members by ensuring that providers meet state and federal regulatory requirements and accreditation standards.

During the credentialing and recredentialing process, Maryland Physicians Care obtains information from outside sources such as state licensing agencies and the National Practitioner Data Bank.

If any information gathered as part of the primary source verification process differs from data submitted by the practitioner on the credentialing application, Maryland Physicians Care will notify the practitioner and request clarification.

A written explanation detailing the error or the difference in information must be submitted to Maryland Physicians Care to be included as part of the credentialing and recredentialing process. Information must be sent in a timely manner to avoid delays in the credentialing process.

Practitioners have the right to:

- Review primary source materials collected during this process.
- Request the status of their credentialing application.
- Ask questions about the credentialing process at any time.

Providers can learn more by contacting Provider Services at **1-800-953-8854**.

Guidelines for care

Maryland Physicians Care adopts preventive and clinical practice guidelines based on the health needs of our membership and on opportunities for improvement identified as part of the quality improvement (QI) program.

Guidelines are available for preventive services, as well as for the management of chronic diseases, to assist in developing treatment plans for members and to help them make healthcare decisions. Maryland Physicians Care evaluates providers' adherence to the guidelines at least annually, primarily through monitoring of relevant HEDIS measures.

For the most up-to-date version of our preventive and clinical practice guidelines, go to **MarylandPhysiciansCare.com** or call **1-800-953-8854**.

Visit our website

Find information on:

- Quality improvement program
- Case management program
- Disease management program
- Clinical practice guidelines
- Utilization management
- Pharmacy/prescription drug management
- Benefits and coverage
- Member rights and responsibilities
- Protected health information use and disclosure
- Member handbook
- Provider directory

If you do not have internet service, you can reach us by phone (numbers listed in Who to Call) for more information.

Who to call

Member Services (benefits, ID cards, appeals, PCP changes, etc.):
1-800-953-8854

DentaQuest (adults only):
1-800-685-1150

Healthy Smiles Dental Services:
1-855-934-9812

Public Mental Health Services:
1-800-888-1965

Superior Vision: 1-800-428-8789

Utilization Management (UM):
1-800-953-8854—follow prompts to UM

Case Management/Disease Management: 1-800-953-8854

Health Education Requests:
1-800-953-8854

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