ProviderReport

sunshine health

Clinical practice guidelines

Our clinical and quality programs are formed from evidence-based preventive and clinical practice guidelines. Sunshine Health adopts guidelines based on the health needs of the membership and opportunities for improvement identified as part of the Quality Improvement Program. The guidelines are based on valid and reliable clinical evidence formulated by nationally recognized organizations, government institutions, state-wide collaboratives and/or a consensus of healthcare professionals in the applicable field.

Clinical practice guidelines are reviewed annually and updated to reflect the current standard of care. These guidelines are used for preventive services, as well as for the management of chronic diseases. Sunshine Health providers are expected to follow these guidelines, and adherence is evaluated at least annually as part of the Quality Improvement Program.

The guidelines:

- Consider the needs of the members
- Are adopted in consultation with network providers
- Are reviewed and updated periodically, as appropriate

Preventive and chronic disease guidelines and recommendations include:

- Adult, adolescent and pediatric preventive care guidelines
- Guidelines for diagnosis and treatment of asthma, ADHD, hypertension, diabetes and major depressive disorders.

For the most up-to-date version of preventive and clinical practice guidelines, go to **www.sunshinehealth.com.** A copy may be mailed to your office as part of disease management or other QI initiatives. Members also have access to these guidelines.

Building our network

Sunshine Health offers a network of primary care providers (PCPs) to ensure every member has access to a medical home within the required travel distance standards. Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, physician assistants and advanced registered nurse practitioners.

Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the Agency for Health Care Administration (AHCA) network adequacy requirements for the managed care organization networks. We will develop and maintain a network of qualified providers in sufficient numbers and locations. Providers will be adequate and reasonable in number, in specialty type and in geographic distribution to meet the medical needs of members, both adults and children, without excessive travel requirements, and will be in compliance with HHS access and availability requirements.

Are you thinking of going through the transformation process to become a certified Patient Centered Medical Home? If so, we would like to have a chance to speak with you. Contact us at **1-866-796-0530,** ext. **40447.**

RECORD KEEPING

Sunshine Health requires participating practitioners to maintain uniform, organized medical records that contain patient demographics and medical information regarding services rendered to members.

These standards are intended to help providers keep complete files about all our members. They are consistent with state contract requirements and industry standards.

Medical records must be:

- Complete and systematic
- Confidential
- Maintained for a period of time
- Available for audits

Periodically, Sunshine Health will conduct an on-site medical-record audit of a random sampling of our members and provider offices to evaluate compliance with these standards.

You may view a complete list of record documentation standards in our provider manual, which is available online at **www.sunshinehealth.com**.

SPOTLIGHT

Patient Centered Medical Home

Sunshine Health is pleased to recognize FQHC Economic Opportunity, Jessie Trice Community Health Center. Dr. Claude Jones, Chief Medical Officer of the level III, NCQA-recognized Patient Centered Medical Home (PCMH), states:

"As a Patient Centered Medical Home, we pre-plan our patient visits and anticipate what to expect. This allows us to fully focus on the patient during the visit. We know our patients' chronic conditions and recent health histories in advance. Our care plans emphasize access to care, coordination of care and continuity of care. Patient adherence comes from good rapport. In this way, our patient population will be healthier. You're treating a whole person, not just a medical condition."

If you would like more information about becoming a PCMH, contact Jill Metlin, Director, Medical Management Operations at **1-866-796-0530, ext. 40447** or email **jmetlin@centene.com**.

You can impact HEDIS scores

Sunshine Health strives to provide quality healthcare to our members as measured through HEDIS quality metrics.

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows direct, objective comparison of quality across health plans. NCQA develops the HEDIS measures through a committee composed of purchasers, consumers, health plans, healthcare providers and policy makers.

HEDIS allows for standardized measurement and reporting, and accurate, objective side-by-side comparisons. Learn more at **www.ncqa.org**.

How to improve your scores

To help your practice increase its HEDIS rates, we review key HEDIS measures in each issue of this newsletter. Call Sunshine Health's Quality Improvement Department at **1-866-796-0530** for guidance. Please always follow the state and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission.

Other ways to help your scores include:

- Submit claim/encounter data for each and every service rendered.
- Ensure chart documentation reflects services billed.
- Bill (or report by encounter submission) for services delivered, regardless of contract status.
- Ensure that claim/encounter data is the most clean and efficient way to report HEDIS.
- Do not include services that are not billed or not billed accurately in the calculation.
- Submit accurate and timely claim/encounter data, which will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Consider including CPT II codes to reduce medical record requests. These codes provide details currently only found in the chart, such as BMI screenings and lab results.

Please take note of the HEDIS measures highlighted on the next page regarding flu, women's health screenings and pharyngitis.

HEDIS measures in summary

FLU:

HEDIS measurements include reviews of childhood immunizations, including for influenza. Data on flu vaccine given to adults 18 to 64 is also reviewed using survey methodology.

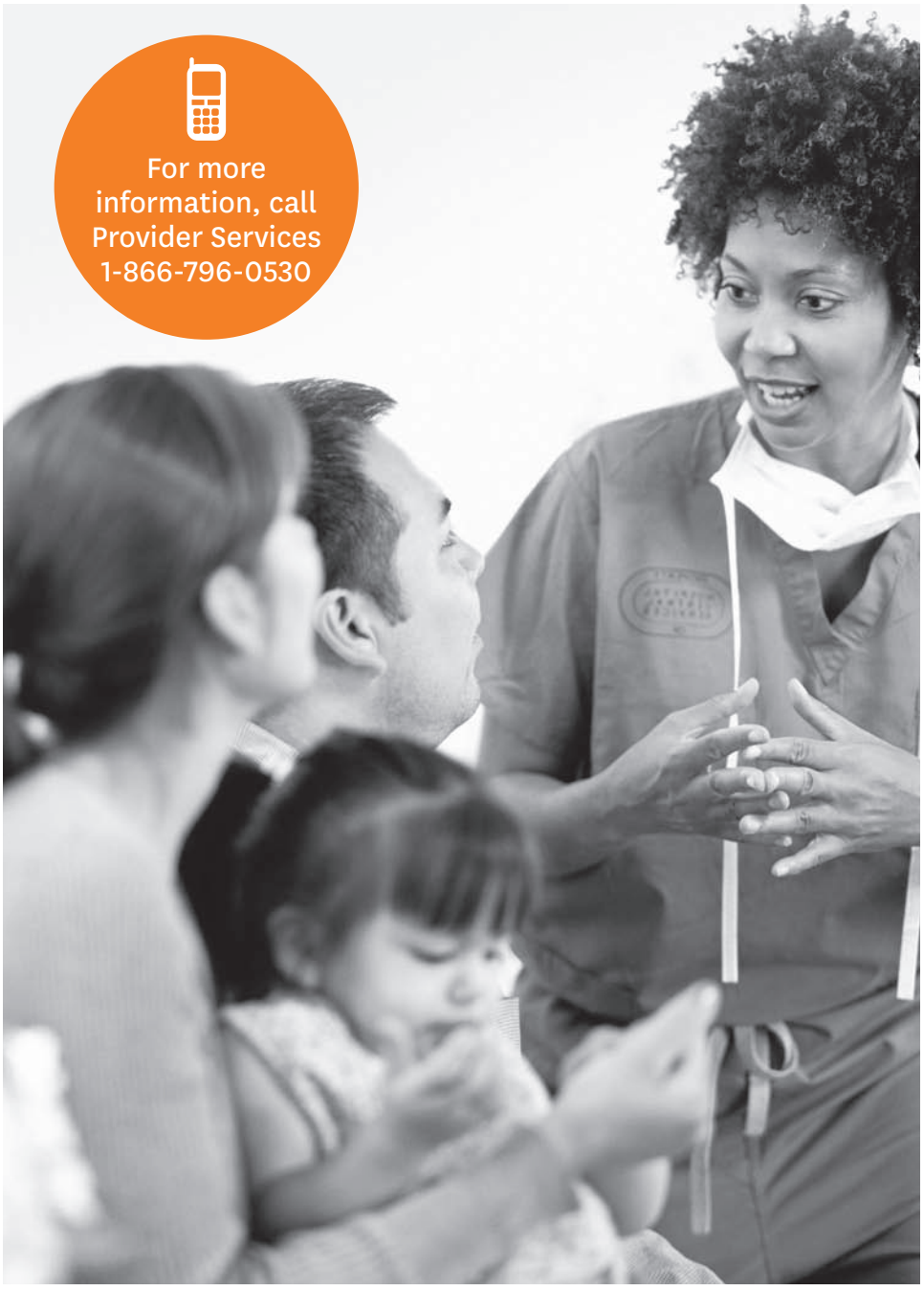
Influenza: At least two doses before age 2

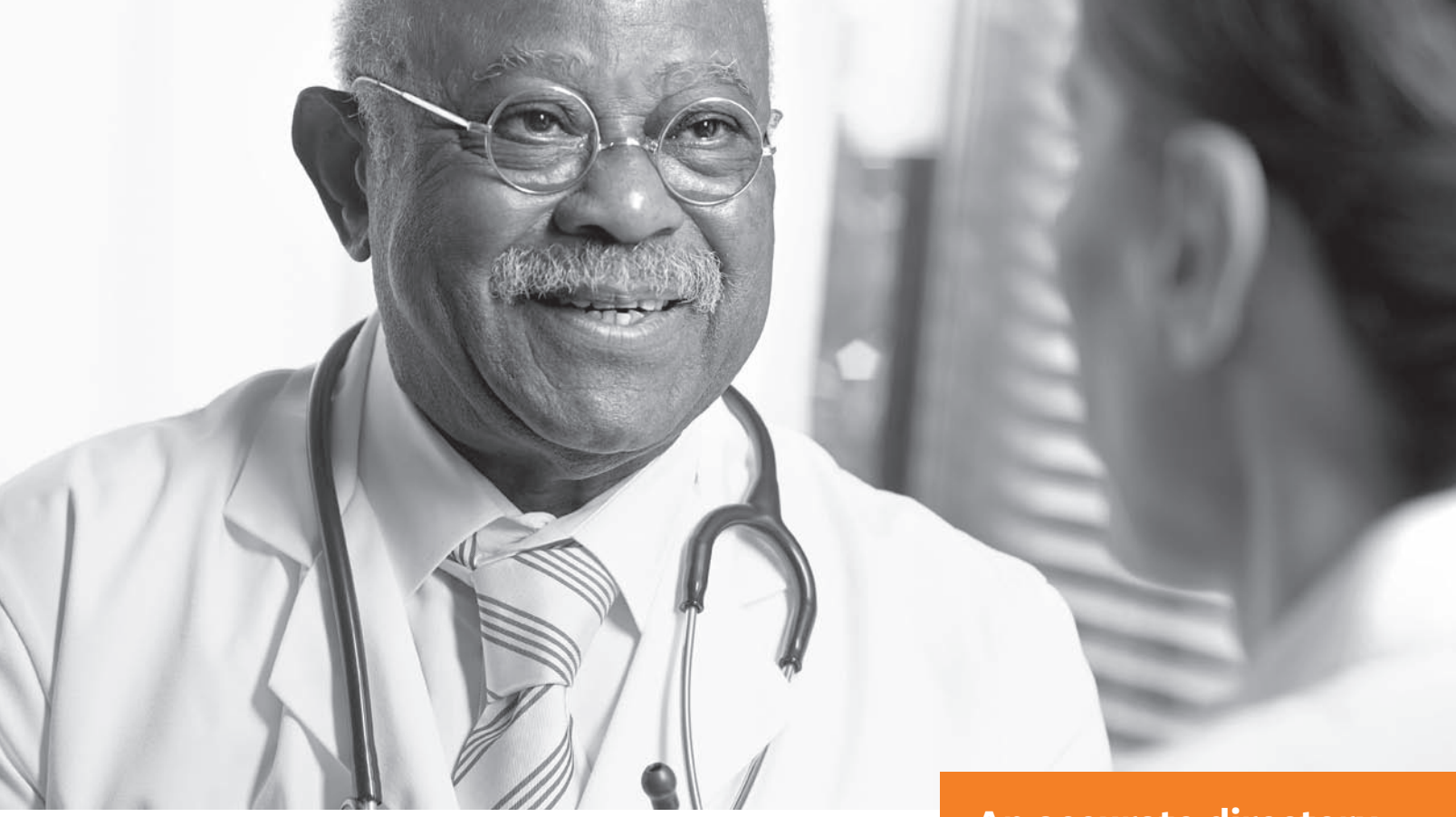
WOMEN'S HEALTH SCREENINGS:

- **Chlamydia screening in women measure:** Evaluates the percentage of women ages 16 to 24 who are sexually active and who had at least one test for chlamydia per year. Chlamydia tests can be completed using any method, including a urine test. "Sexually active" is defined as a woman who has had a pregnancy test or testing for any other sexually transmitted disease or has been prescribed birth control.
- **Breast cancer screening measure:** Evaluates the percentage of women ages 50 to 74 who had a mammogram at least once in the past two years. Women who have had a bilateral mastectomy are exempt from this measure.
- **Cervical cancer screening measure:** Evaluates the percentage of women ages 21 to 64 who were screened for cervical cancer using either of the following criteria: 1) Cervical cytology performed every three years for women ages 21-64; 2) Cervical cytology/human papillomavirus (HPV) co-testing performed every five years (must occur within four days of each other) for women ages 30-64. Women who have had a hysterectomy without a residual cervix are exempt from this measure.
- **Postpartum visits measure:** Evaluates the percentage of women who delivered a baby and who had their postpartum visit on or between 21 and 56 days after delivery (three and eight weeks).
- **Prenatal visits/timeliness of first visit and frequency of visits measure:** Evaluates the percentage of pregnant women who had their first prenatal visit in the first trimester or within 42 days of enrollment with the plan. The frequency of prenatal visits is also assessed.

PHARYNGITIS & UPPER RESPIRATORY:

- **Appropriate testing for children with pharyngitis measure:** Evaluates the percentage of children ages 2-18 diagnosed with pharyngitis, dispensed an antibiotic and given a group A streptococcus (strep) test for the episode. A higher rate represents better performance (that is, appropriate testing). Rapid strep tests in the office are acceptable and should be billed.
- **Appropriate treatment for children with upper respiratory infection measure:** Assesses the percentage of children ages 3 months to 18 years who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. Ensure any secondary diagnoses indicating the need for an antibiotic are submitted on the claim.





What's your **availability?**

Availability is defined as the extent to which Sunshine Health contracts with the appropriate type and number of practitioners necessary to meet the needs of its members within defined geographic areas. The availability of our network practitioners is key to member care and treatment outcomes.

We evaluate compliance with these standards on an annual basis and use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

TYPE OF APPOINTMENT	SCHEDULING TIME FRAME
Routine care (without symptoms)	Within 30 days
Routine care (with symptoms)	Within seven days
Post hospital discharge follow-up	Within seven days
Emergency care	Same day
Urgent care	Within 24 hours

An accurate directory

Have you moved or changed contact information? Or maybe your practice is not listed accurately in our Provider Directory? You can request changes via our secure provider portal at www.sunshinehealth.com or by calling 866-796-0530. Please let us know at least 30 days before you expect a change to your demographic information.

REMINDER

Providers should under no circumstances write on paper claims. They are automatically rejected and the provider will need to resubmit, which delays processing and payment. Any verbiage needed regarding a corrected claim can be entered on the resubmission form sent in with the claim or any letter that providers may submit to aid with processing.

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