



Q&A: Credentialing rights

What happens during the credentialing and recredentialing process?

Sunshine Health 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.

How can I review these sources?

The information may be released to practitioners only after a written and signed request has been submitted to the Credentialing Department.

What if there is a discrepancy between these sources and the information I provide?

If any information gathered as part of the primary source verification process differs from data

submitted by the practitioner on the credentialing application, Sunshine Health will notify the practitioner and request clarification.

How can I respond to any discrepancy?

A written explanation detailing the error or the difference in information must be submitted to Sunshine Health within 14 days of notification of the discrepancy in order to be included as part of the credentialing and recredentialing process.

How can I learn the status of my application?

Providers also have the right to request the status of their credentialing or recredentialing application any time by contacting the Credentialing Department at **1-866-796-0530**.

Hours of operation policies

We encourage you to review your hours of operation policy to ensure that you are offering Medicaid members the same hours as commercial members, as required by the National Committee for Quality Assurance (NCQA).

Medicaid law requires that providers give equal offerings in terms of hours and appointments to Medicaid and non-Medicaid patients. If you are a provider that only sees Medicaid patients, you must provide parity of hours to Medicaid managed care members and Medicaid fee-for-service members.

Please note that NCQA will review provider contracts, manuals and marketing materials for any language that suggests hours of operation are different for Medicaid and non-Medicaid patients.

HEDIS FOR DIABETES

The HEDIS measure for comprehensive diabetes care includes adult patients with Type I and Type II diabetes. There are multiple sub-measures included:

- 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
 - HbA1c result < 8.0 = good control
 - HbA1c result < 7.0 for selected population
- Blood pressure control— < 140/90
- Dilated retinal eye exam—annually, unless the exam the year prior was negative, then every two years
- Nephropathy screening test—macroalbumin or microalbumin urine test at least annually (unless documented evidence of nephropathy)

What providers can do

1. Dilated retinal eye exam:

Sunshine Health can assist your office with finding a vision provider. Our vision vendor supports our efforts by contacting members in need of retinal eye exams to assist them in scheduling an appointment.

2. Nephropathy screening

test: Did you know 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?

WE ARE HERE TO HELP

Contact us at 1-866-796-0530 to speak with our provider services team. Explore our site for tools and tips about utilization management, quality improvement, prior authorization and more.

To learn more about our provider services, please check our provider manual, available at www.sunshinehealth.com.

If you or one of our members would like a paper copy of anything found on our website, please call 1-866-796-0530.

Help your patients, help our **HEDIS** scores

HEDIS, the Healthcare Effectiveness 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 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 the performance of health care plans. Final HEDIS rates are typically reported to NCQA and state agencies once a year.

Through HEDIS, NCQA holds Sunshine Health

accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership. Sunshine Health also reviews HEDIS rates on an ongoing basis and continually looks for ways to improve our 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 of the provider newsletter: diabetes, hypertension, and cardiac health. Also, please review Sunshine Health's clinical practice guidelines at www.sunshinehealth.com.



HEDIS for heart care

The high blood pressure control HEDIS measure applies to patients who have been diagnosed with hypertension (excluding individuals with end-stage renal disease and pregnant women). The HEDIS measure evaluates the percentage of patients with hypertension with adequate control (defined as a systolic reading of less than 140 mm Hg and a diastolic reading of less than 90 mm Hg, or 140/90). For patients ages 60-85, adequate control is defined as less than 150/90.

The HEDIS measure for persistence of a beta-blocker treatment regimen after heart attack applies to patients who were hospitalized and discharged after an acute myocardial infarction (AMI). This measure calls for treatment with beta-blockers for six months after discharge. Patients with a known contraindication or a history of adverse reactions to beta-blocker therapy are excluded from the measure. Despite strong evidence of the effectiveness of drugs for cardiac problems, patient compliance remains a challenge.

What providers can do

- Continue to suggest and support lifestyle changes such as quitting smoking, losing excess weight, beginning an exercise program and improving nutrition.
- Stress the value of prescribed medications for managing heart disease. Sunshine Health can provide educational materials and other resources addressing the above topics.
- Encourage your Sunshine Health patients to contact Sunshine Health for assistance in managing their medical condition. Sunshine Health case management staff members are available to assist with patients who have challenges adhering to prescribed medications or have difficulty filling their prescriptions. If you have a member you feel could benefit from our case management program, contact Sunshine Health member services at **1-866-796-0530** and ask for medical case management.

New technology, new coverage

Sunshine Health evaluates the inclusion of new technology and new applications of existing technology for coverage determination on an ongoing basis. We may provide coverage for new services or procedures that are deemed medically necessary. This may include medical and behavioral health procedures, pharmaceuticals or devices.

Requests for coverage will be reviewed and a determination made regarding any benefit changes that are indicated. When a request is made for new technology coverage on an individual case and a plan-wide coverage decision has not been made, Sunshine Health will review all information and make a determination on whether the request can be covered under the member's current benefits, based on the most recent scientific information available.

For more information, please call **1-866-796-0530**.

REVIEW OF DENIALS

Sunshine Health sends you and your patients written notification any time a decision is made to deny, reduce, suspend or stop coverage of certain services. 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 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 Sunshine Health at **1-866-796-0530**. 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 the 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 for Sunshine Health to make timely medical necessity decisions based on complete information.

Member satisfaction survey results

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 (NCQA) 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. Sunshine Health will be using the results to make improvements.

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

Here are some key findings from the survey:

Areas where we scored well include:

- Rating of health plan
- Rating of health care
- Getting care quickly
- How well doctors communicate

Some of the areas we have been working to improve include:

- Providing needed information
- Flu vaccinations
- Advising smokers to quit

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



Improving health outcomes in Medicaid patients with mental illness

Take note of Florida's psychotherapeutic medication guidelines.

The University of South Florida's *Medicaid Drug Therapy Management Program for Behavioral Health* (MDTMP) was established in 2005 to collaborate with Medicaid program prescribers to improve the quality and efficiency of mental health medication prescribing and improve the health outcomes of Medicaid beneficiaries with a mental illness.

With a goal of improved collaboration and better health outcomes, USF's MDTMP program has established guidelines that cover a broad range of mental health conditions. These conditions include ADHD, anxiety disorders, bipolar disorder, severe or chronic impulsive aggression, depression, obsessive compulsive disorder (OCD) and more.

Please review the guidelines for updates and/or areas of opportunity for the care of this population as we strive to improve health outcomes.

Newly updated guidelines are now available:

- Florida Psychotherapeutic Medication Guidelines for Children and Adolescents
- Florida Best Practice Psychotherapeutic Medication Guidelines for Adults
- Autism Spectrum Disorder & Intellectual Disability Disorder
- A Summary for Monitoring Physical Health and Side Effects of Psychiatric Medications in the Severely Mentally Ill Population

To review the guidelines or obtain copies, visit the USF MDTMP Psychotherapeutic Medication Treatment Guidelines' website: <http://medicaidmentalhealth.org>.

Provider **web portal**

Sunshine Health's website (www.sunshinehealth.com) gives providers secure access to resources, education and training.

NON-SECURE PROVIDER PORTAL	SECURE PROVIDER PORTAL
• Manuals and resources	• Member eligibility and patient listings
• Preferred drug list (PDL)	• Health records and care gaps
• Forms and guides	• Authorizations
• Provider news and educational materials	• Claims submissions and status
	• Corrected claims and adjustments
	• Payments history
	• Monthly PCP cost reports

PCP reports available on Sunshine Health's secure web portal are generated on a monthly basis and can be exported into a PDF or Excel format.

PCP reports:

- Patient list with HEDIS care gaps
- Rx claims reports
- Emergency room visits
- High-cost claims



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