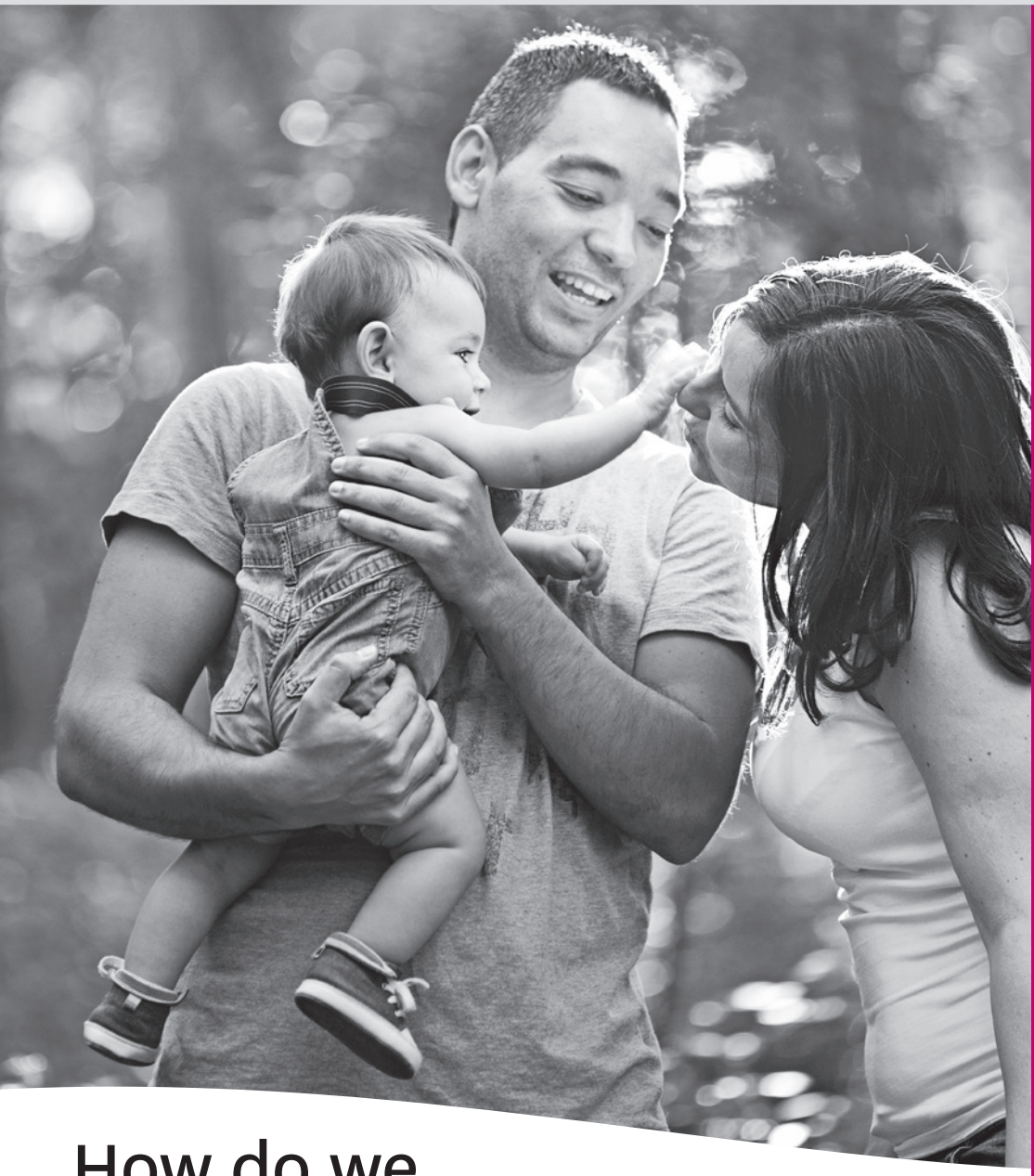
ProviderReport

ambetter. of Arkansas



How do we measure quality?

Ambetter of Arkansas uses the Healthcare Effectiveness Data and Information Set (HEDIS), which provides a standardized method for managed care organizations to collect, calculate and report information about their performance. This allows employers, purchasers and consumers to compare different plans. Health plans use HEDIS results themselves to see where they need to focus their improvement efforts.

Many of the measures are evaluating how you, the provider, are meeting the needs of the member. We strive to partner with you to improve the overall health of our members.

HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and services.

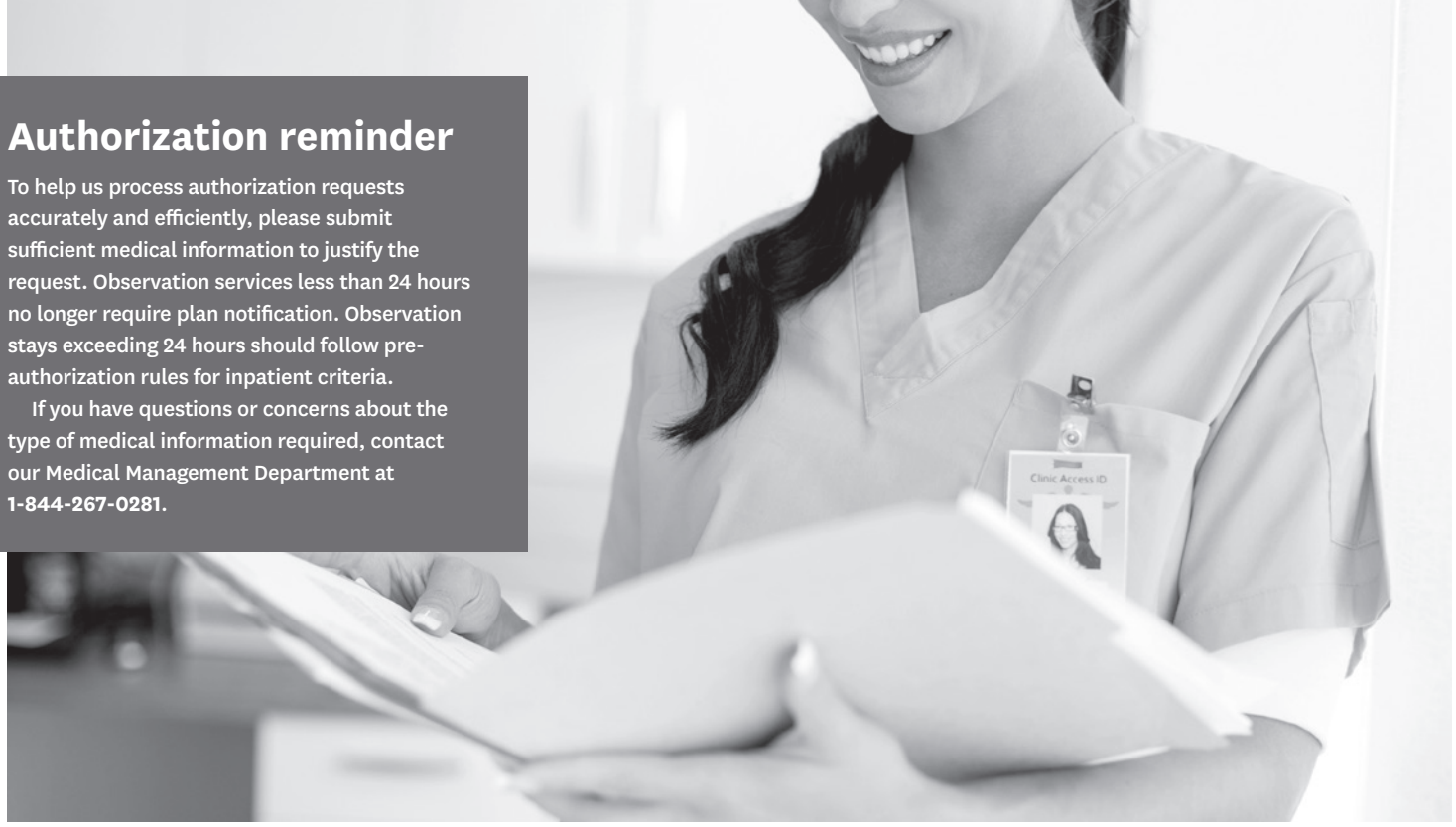
Let our guidelines be your guide

Our preventive care and clinical practice guidelines are based on health needs of our members and opportunities for improvement identified as part of our Quality Improvement (QI) program. When possible, we adopt preventive and clinical practice guidelines that are published by nationally recognized organizations, government institutions and statewide initiatives. These guidelines have been reviewed and adopted by our QI Committee. We encourage providers to use these guidelines as a basis for developing personalized treatment plans for our members and to aid members in making decisions about their healthcare. They should be applied for both preventive services as well as for management of chronic diseases.

Preventive and chronic disease guidelines cover the following:

- ADHD
- Adult and child preventive services
- Asthma
- Breast cancer
- Depression
- Diabetes
- Immunizations, including influenza and pneumococcal

We measure compliance with these guidelines by monitoring related HEDIS measures and through random audits of ambulatory medical records. Our preventive care and clinical practice guidelines are intended to augment—not replace—sound clinical judgment. Guidelines are reviewed and updated annually or upon significant change.



Authorization reminder

To help us process authorization requests accurately and efficiently, please submit sufficient medical information to justify the request. Observation services less than 24 hours no longer require plan notification. Observation stays exceeding 24 hours should follow pre-authorization rules for inpatient criteria.

If you have questions or concerns about the type of medical information required, contact our Medical Management Department at **1-844-267-0281.**

THANK YOU FOR YOUR FEEDBACK

Ambetter of Arkansas recently conducted our annual Provider Satisfaction Survey. If you participated, thank you.

Survey questions covered a range of topics, including provider relations, coordination of care, utilization, finance and overall satisfaction. Your feedback will guide our improvement efforts over the next year.

Specifically, we plan to focus on the following areas for improvement:

- Provider communication
- Onsite provider visits
- Quarterly provider newsletter
- Provider portal resources
- Member & provider HEDIS education mailouts

The appropriate use of resources

Ambetter of Arkansas and its partners have utilization and claims management systems in place to identify, track and monitor care provided to our members. We want to ensure members have access to appropriate, quality care.

We do not reward practitioners, providers or employees who perform utilization reviews or issue denials of coverage or care. Utilization management (UM) decision-making is based only on appropriateness of care, service and existence of coverage.

Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Denials are based on lack of medical necessity or lack of covered benefit.

Utilization review criteria have been developed to cover medical and surgical admissions, outpatient procedures and ancillary services. Ambetter of Arkansas uses nationally recognized criteria (e.g. InterQual) if available for the specific service; other criteria are developed internally through a process which includes thorough review of scientific evidence and input from relevant specialists. Criteria are periodically evaluated and updated with appropriate involvement from physician members of our UM Committee.

Providers may obtain the criteria used to make a specific decision by contacting the Medical Management Department at Ambetter of Arkansas. Practitioners also have the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer at the time of notification

Learn more: Our UM staff is available from 8 a.m. to 5 p.m. CST at **1-844-267-0281**.

Behavioral health services for your patients

If you have patients who struggle with depression, anxiety, substance abuse or other behavioral health conditions, we have resources to help. Ambetter of Arkansas offers our members access to all covered, medically necessary behavioral health services. You can learn more about our behavioral health services at **www.cenpatico.com**. For help identifying a behavioral health provider or for prior authorization for inpatient or outpatient services, call **1-877-617-0390**.

COUNTDOWN TO ICD-10

Effective October 1, 2015, all HIPAA-covered entities including providers, payers, vendors and their business associates must transition to ICD 10 regardless of their acceptance of Medicaid or Medicare. Ambetter of Arkansas will be ICD 10 compliant for the October 1, 2015 implementation date.

If you are not already doing so, Ambetter of Arkansas encourages you to begin preparing for the implementation of ICD 10 in order to avoid cash flow issues. Our website, **AmbetterofArkansas.com**, features valuable information regarding the conversion to ICD 10, including links to the CMS ICD 10 site, as well as other industry news and resources.

REMEMBER

- Claims with dates of service prior to October 1, 2015, must be coded utilizing ICD 9 coding even if the claim is submitted after October 1, 2015.
- Claims with dates of service after October 1, 2015, must be coded utilizing ICD 10 coding.
- Visit **AmbetterofArkansas.com** for more information about ICD 10, including FAQs, testing instructions and additional support.

Member rights and responsibilities: A shared agreement

Ambetter of Arkansas' member rights and responsibilities address members' treatment, privacy and access to information. We have highlighted a few below. There are many more and we encourage you to consult your provider manual to review them. You can find the complete provider manual online at **AmbetterofArkansas.com** or get a printed copy by calling **1-877-617-0390**.

Member rights include, but are not limited to:

- Receiving all services that Ambetter of Arkansas must provide
- Assurance that member medical record information will be kept private
- Being able to ask for, and get, a copy of medical records, and being able to ask that the records be changed or corrected if needed

Member responsibilities include:

- Asking questions if they don't understand their rights
- Keeping scheduled appointments and having an ID card with them
- Always contacting their primary care physician (PCP) first for non-emergency medical needs
- Notifying their PCP of emergency room treatment

Could case management benefit your patients?

Medical case management is a collaborative process that assesses, plans, implements, coordinates and evaluates options and services to meet an individual's health needs. It relies on communication and resources to promote quality and cost-effective outcomes.

Ambetter of Arkansas case management is intended for high-risk, complex or catastrophic conditions—including transplant candidates and members with special healthcare needs and chronic conditions, such as asthma, diabetes, HIV/AIDS and congestive heart failure.

Case managers do not offer hands-on medical care or treatment. They do not diagnose conditions or prescribe medication. A case manager can help a patient understand the benefits of following a treatment plan and the consequences of not following the plan outlined by the physician. In this way, they become a resource for the healthcare team, the member, as well as the member's family.

Our case management team is here to support your team for such events as non-adherence, new diagnosis and complex multiple comorbidities.

Providers can directly refer members to our case management program at any time. Please call **1-844-267-0281** for additional information about the case management services offered or to initiate a referral. Learn more about our case management services at **AmbetterofArkansas.com**.

Goals of disease management

As part of our medical management and quality improvement efforts, we offer members disease management programs. The goals of disease management include:

- Promote coordination among the medical, social and educational communities
- Ensure referrals are made to the proper providers
- Encourage family participation
- Provide education regarding a member s condition to encourage adherence and understanding
- Support the member s and caregiver s ability to self-manage chronic conditions
- Identify modes of delivering coordinated care services, including home visits

These programs are intended for patients with conditions such as asthma, diabetes and high-risk pregnancies. Learn more about our disease management services at **AmbetterofArkansas.com** or by calling **1-877-617-0390**.

Clinical Lab Improvement Act (CLIA) billing reminders

CLIA numbers are required for CMS 1500 claims where CLIA Certified or CLIA waived services are billed. If the CLIA number is not present, the claim will be rejected up front. For billing instructions on how and/or where to provide the CLIA certification or waiver number, please reference the Ambetter of Arkansas Provider Manual available at **AmbetterofArkansas.com**

Medical record **maintenance**

Consistent and complete documentation in medical records is an essential part of quality care. We ask that participating practitioners keep uniform and organized medical records that contain member demographics and medical information regarding services rendered.

Medical records must be maintained in an organized system in compliance with our medical documentation and record-keeping standards. The intent with these standards is to help practitioners maintain complete medical records for all members, consistent with industry standards, and to meet state contract requirements.

A complete medical record must be maintained on each member for whom the practitioner has rendered healthcare services. These records must be protected from public access and any information released must comply with HIPAA guidelines.

Upon request, all participating practitioner medical records must be available for utilization review and QI studies—including HEDIS—as well as regulatory agency requests and member relations inquiries, as stated in the provider agreement.

Additionally, practitioners must provide a copy of a member's medical record upon reasonable request by the member at no charge.

The following is a list of the minimum required standards for practitioner medical record-keeping practices:

ORGANIZATION AND CONFIDENTIALITY

- Records are organized and stored in a manner that allows easy retrieval.
- Records are stored in a secure manner that allows access by authorized personnel only.
- Staff receive periodic training in member information confidentiality.

DEMOGRAPHIC CONTENT

Records should include:

- Patient identification information (patient name or identification number) on each written page or electronic file record
- Identity of the provider rendering the service

CLINICAL CONTENT

Records should include:

- All services provided directly by a practitioner who provides primary care services
- Date that the service was rendered
- All ancillary services and diagnostic tests ordered by the practitioner
- An explicit notation in the record for follow-up plans for abnormal lab and imaging study results; all entries should be initialed and dated by the ordering practitioner to signify review
- Documentation of all diagnostic and therapeutic services for which a member was referred to by a practitioner, including follow-up of outcomes and summaries of treatment rendered elsewhere such as: home health nursing reports, specialty physician reports, hospital discharge reports (emergency room and inpatient) and physical therapy reports
- History and physicals
- Allergies and adverse reactions (prominently documented in a uniform location)
- Problem list
- Medications
- Immunization records
- Documentation of clinical findings and evaluation for each visit (including appropriate treatment plan and follow-up schedule)
- Preventive services / risk screenings provided
- Documentation of health teaching, counseling and/or age appropriate anticipatory guidance
- Advance directives
- Documentation of failure to keep an appointment
- Documentation of physical health medical record information sent to behavioral health providers, if applicable
- Documentation of cultural, interpretation or linguistic needs; if not applicable, then documented as N/A

Four facts about credentialing and re-credentialing

1. Practitioners are sent a re-credentialing application at least 180 days in advance of their last re-credentialing date. To be re-credentialed, all practitioners must meet specific criteria. In addition, a medical record review by Quality Improvement staff may be required. You can review further details about credentialing requirements in our provider manual on **AmbetterofArkansas.com** under Provider Resources.
2. During the credentialing and re-credentialing process, we obtain information from various outside sources, such as state licensing agencies and the National Practitioner Data Bank. Practitioners have the right to review materials collected during this process. The information may be released to practitioners only after a written and signed request has been submitted to the Credentialing Department.
3. If any information gathered as part of the primary source verification process differs from data submitted by the practitioner on the credentialing application, we will notify the practitioner and request clarification. A written explanation detailing the error or the difference in information must be submitted to Ambetter of Arkansas within 30 days of notification of the discrepancy in order to be included as part of the credentialing and re-credentialing process.
4. Providers also have the right to request the status of their credentialing or re-credentialing application any time by contacting the Credentialing Department at **1-877-617-0390** or **AmbetterofArkansas.com**.

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