CalOptima Care Network (CCN)

Provider Lunch and Learn Meeting for CCN Contracted Providers

Tuesday, February 3, 2015

12:05–2 p.m.

Agenda

I.	**Welcome and Introductions**	**Ted Holloway** *Manager,* *Member Outreach Education and Provider Relations*	**12:05–12:10**
II.	**Provider Relations Updates**	**Jorge Castaneda** *Provider Relations Representative*	**12:10–12:20**
III.	**Crossover Claims**	**Anita Allen** *Manager,* *Claims Administration*	**12:20–12:40**
IV.	**CalOptima Medi-Cal Fee Schedule Overview**	**Janine Kodama** *Manager,* *Coding Quality*	**12:40–12:55**
V.	**Healthcare Effectiveness Data and Information Set (HEDIS)**	**Mary Botts** *Manager, HEDIS*	**12:55–1:10**
VI.	**Q & A and Closing Remarks**	**Ted Holloway** *Manager,* *Member Outreach Education and Provider Relations*	**1:10–2**

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CalOptima Care Network (CCN)

Lunch and Learn Meeting

February 3, 2015

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Welcome

Ted Holloway, Manager

Member Outreach, Education & Provider Relations

Agenda

- Provider Relations Updates
- Crossover Claims
- CalOptima Medi-Cal Fee Schedule Overview
- HEDIS
- Q&A and Closing Remarks

CCN Meeting Materials

- Meeting Agenda
- Notes page
- CCN Question Sheet
  - Complete if you would like CalOptima staff to follow up with you after this meeting.
- Today's Meeting Evaluation
  - Please complete at the end of each presentation.
- Meeting materials are available on the provider webpage at www.caloptima.org.

Please place your cell phones on silent

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Provider Relations

Lunch and Learn

February 3, 2015

Jorge Castañeda

Provider Relations Representative

CCN Lunch and Learn Q & A

- Evaluation Form — Please complete and leave behind.
- In your packet, there is a form on which you can write any questions about anything that we have not addressed today.
- What questions do you still have?

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner


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Provider Relations

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Jorge Castañeda

Provider Relations Representative

Provider Relations Updates

- ACA Payment for CHDP Services
- Community Network
- New CalOptima Members
- Access and Availability

ACA Payment for CHDP Services

- Payment for the 2nd half of 2013
- Network payments were mailed first week of January 2015
- Networks must distribute payment to its providers within 60 days
- CCN/COD checks were printed on 01/17/15 and mailed to providers the following week

CalOptima Community Network

- CalOptima Community Network to be available for Medi-Cal members on March 1, 2015
- Contracts were mailed to providers at the end of 2014
- Deadline to return contracts was January 31, 2015

Additional Members on January 1, 2015

- Covered California is required to annually verify a member's eligibility, during the member's eligibility redetermination month.
- Individuals of lower income are moved from Covered California to Medi-Cal.
- Across the state, approximately 95,000 people transitioned to Medi-Cal on January 1, 2015.
- Estimated 8,500 people transitioned to CalOptima on January 1, 2015.

Access and Availability

- CalOptima is updating the online directory.
  - Hours of operation
  - Languages spoken
  - Hospital affiliation

- Provider representatives are available and conducting regular office visits.

Crossover Claims

CCN Lunch & Learn

February 3, 2015

Anita Allen

Manager, Claims Administration

Holly Dinh

Program Specialist, Claims Administration

What Are Crossover Claims?

- A crossover is a claim where the recipient is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for the remaining balance (which is applied to the deductible and/or coinsurance). Medi-Cal's reimbursement is limited, when combined with the Medicare payment and should not exceed Medi-Cal's maximum allowed for similar services.
- As secondary payer, CalOptima will only reimburse up to the Medi-Cal maximum amount, not to exceed the coinsurance/deductible amounts.

Important Information

- On June 1, 2014 crossover claims transitioned from our external vendor to CalOptima's in-house Claims Administration Department
- The mailing address is CalOptima, P.O. Box 11070, Orange, CA 92856
- Customer Service (714) 246-8885
- Crossover appeals continue to use the CIF (Claim Inquiry Form). Submit your CIFs to CalOptima, P.O. Box 11070, Orange, CA 92856.

Recoupment on Provider Crossover Claims July 26, 2011 to May 21, 2013

- We are in active discussions with DHCS to secure a file that we can use to process claims to prevent providers from having to resubmit take-back claims. Although some of our providers are able to provide the detail needed to process these claims, the vast majority do not have the capability without creating an administrative burden.
- DHCS has confirmed that they have pulled the report using a field in their file that is populated by providers to indicate their health plan's affiliation. In reviewing the report, they have found that fewer than three percent of the providers submitted health plan information on the claims affected by the take back.

Recoupment on Provider Crossover Claims July 26, 2011 to May 21, 2013

- DHCS has now engaged a consultant to assist in cross-walking the claims information with the member eligibility file to determine health plan affiliation. We are in the process of providing them with the fields that we would like to see on the reports and they have asked that we give them another few weeks to complete this task.

Questions About The Crossover Take-Back Issue

Why is CalOptima waiting for the state file when I can provide the data today for my organization?

- CalOptima is sensitive to the financial and administrative impact the take-back project has presented for all affected providers. It is our goal to provide a solution to this issue that does not involve manual claims submission.
- The state file will provide information regarding the full amounts the state expects to be recouped, not just the amounts recouped thus far, so we will have a complete picture of the financial impact. The state is not planning future recoupment but there are providers with outstanding recoupment balances that are pending new claims submissions to offset.

Questions About The Crossover Take-Back Issue

What should I expect from CalOptima once you have received the report?

- It is CalOptima's goal to review the report and develop a processing strategy for these take-back claims that would expedite processing. Once the strategy is approved by our executive team, CalOptima will notify all affected providers explaining our plan and the expected time frame to complete processing.

Questions About The Crossover Take-Back Issue

What is happening with the paper claims I have already submitted?

- These claims are being held until we receive and review the state report. Again our goal is to eliminate the need to submit paper claims, so please do not submit additional documents unless instructed to do so in our processing strategy communication.

Will we receive interest payment on these claims once they are processed?

- The subject of interest payments will be addressed in our processing strategy communication as part of our approved plan.

Thank you again for your continued patience!

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CalOptima Medi-Cal Fee Schedule Overview

February 3, 2015

Janine Kodama

Coding Quality Manager

Topics to Discuss

- Overview — CalOptima Pricing Methodology
- Review of Medi-Cal Rates
  - Basic rate
  - Child rate
  - ER rate
  - Cutback rate
  - Professional and technical component

Overview

- CalOptima reimburses **non-contracted** providers for **covered services** at the same amount paid by the Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal fee-for-service (FFS) program.

- California Children's Services (CCS) paneled specialists are paid at 140 percent of the CalOptima Medi-Cal FFS rate effective for the date of service for members younger than 21 years of age.

- DHCS updates the Medi-Cal Fee Schedule monthly.

Sample of Medi-Cal Fee Schedule

	CPT codes and descriptors are copyright 2002 American Medical Association								Medi-Cal Rates as of 10/15/2014			
Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %	Rental Rate	Non-Physn Med Prac Ind
1	99201	OFFICE/OUTPATIENT VISIT NEW	11.41	$11.41	---	$11.41	009	1	0	0.00	$0.00	Y
P	99201	OFFICE/OUTPATIENT VISIT NEW	2.29	$22.90	$24.98	--	052	0	1	0.00	$0.00	Y
P	99202	OFFICE/OUTPATIENT VISIT NEW	3.43	$34.30	$37.42	--	052	0	1	0.00	$0.00	Y
1	99202	OFFICE/OUTPATIENT VISIT NEW	34.30	$34.30	---	$34.30	009	1	0	0.00	$0.00	Y
N	99202	OFFICE/OUTPATIENT VISIT NEW	3.43	$34.30	$37.42	$42.60	001	1	1	0.00	$0.00	Y
N	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	$71.04	001	1	1	0.00	$0.00	Y
1	99203	OFFICE/OUTPATIENT VISIT NEW	57.20	$57.20	---	$57.20	009	1	0	0.00	$0.00	Y
P	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	--	052	0	1	0.00	$0.00	Y

http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp

Procedure Type

- Denotes the procedure or record type

Type	Procedure	Type	Procedure
I	Injection	P	Podiatrist
J	Anesthesia	1	Allied Health and other programs
K	Primary Surgeon	3	Vision Care
O	Assistant Surgeon	E	Local Education Agency
L	Radiology	F	EAPC
M	Pathology and Clinical Lab	G	AIDS Waiver
N	Medicine		

Basic Rate

- Rates for physician services are reimbursable to physicians, physician groups, and non-physician medical practitioners, and for procedure type “P” podiatrists.

- A value of “0.00” or “0.01” means the procedure is **by report** and priced by CalOptima.

Basic Rate Example

	CPT codes and descriptors are copyright 2002 American Medical Association								Medi-Cal Rates as of 10/15/2014			
Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %	Rental Rate	Non-Physn Med Prac Ind
N	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	$71.04	001	1	1	0.00	$0.00	Y
1	99203	OFFICE/OUTPATIENT VISIT NEW	57.20	$57.20	---	$57.20	009	1	0	0.00	$0.00	Y
P	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	--	052	0	1	0.00	$0.00	Y

E&M Visit for Adult — 99203

- Medi-Cal/CalOptima Basic Rate = **$57.20**

Child Rate

Selected primary care services are reimbursed for children age 17 years or under. CalOptima utilizes the “Child Rate” listed on the Medi-Cal Fee Schedule.

	CPT codes and descriptors are copyright 2002 American Medical Association								Medi-Cal Rates as of 10/15/2014			
Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %	Rental Rate	Non-Physn Med Prac Ind
N	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	$71.04	001	1	1	0.00	$0.00	Y
1	99203	OFFICE/OUTPATIENT VISIT NEW	57.20	$57.20	---	$57.20	009	1	0	0.00	$0.00	Y
P	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	--	052	0	1	0.00	$0.00	Y

Child Rate Example

	CPT codes and descriptors are copyright 2002 American Medical Association								Medi-Cal Rates as of 10/15/2014			
Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %	Rental Rate	Non-Physn Med Prac Ind
N	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	$71.04	001	1	1	0.00	$0.00	Y
1	99203	OFFICE/OUTPATIENT VISIT NEW	57.20	$57.20	---	$57.20	009	1	0	0.00	$0.00	Y
P	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	--	052	0	1	0.00	$0.00	Y

E&M Visit for Child — 99203

- Medi-Cal/CalOptima Child Rate: **$62.41**

ER Rate

- Selected medical and surgery services are reimbursed at a higher rate when performed in a hospital emergency room.
  - Caution: the rates in this column only apply if the procedure is a Medi-Cal benefit for an ER place of service (POS 23).

ER Rate Example

	CPT codes and descriptors are copyright 2002 American Medical Association								Medi-Cal Rates as of 10/15/2014			
Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %	Rental Rate	Non-Physn Med Prac Ind
N	99291	CRITICAL CARE FIRST HOUR	12.16	$121.60	$132.67	$151.03	001	1	0	0.00	$0.00	Y

Critical Care Service in the Emergency Room (POS 23) — 99291

- Medi-Cal/CalOptima ER Rate: **$151.03**

Cutback Rate

- Selected medical services are subject to a **20 percent rate reduction** of the Medi-Cal Fee Schedule when performed in a hospital outpatient (POS 22) or in a surgical clinic (POS 24).
- CalOptima utilizes the “Cutback Ind” on the Medi-Cal Fee Schedule.

Cutback Rate Example

	CPT codes and descriptors are copyright 2002 American Medical Association								Medi-Cal Rates as of 10/15/2014			
Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %	Rental Rate	Non-Physn Med Prac Ind
N	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	$71.04	001	1	1	0.00	$0.00	Y
1	99203	OFFICE/OUTPATIENT VISIT NEW	57.20	$57.20	---	$57.20	009	1	0	0.00	$0.00	Y
P	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	--	052	0	1	0.00	$0.00	Y

E&M Visit in the Outpatient Setting (POS 22) — 99203

- Medi-Cal/CalOptima Cutback Rate: $57.20 - $11.44 (20 percent) = **$45.76**

Example — Dual Pricing Method

If the member is a child and the services are performed in an outpatient setting, the Cutback Rate applies.

	CPT codes and descriptors are copyright 2002 American Medical Association								Medi-Cal Rates as of 10/15/2014			
Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %	Rental Rate	Non-Physn Med Prac Ind
N	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	$71.04	001	1	1	0.00	$0.00	Y
1	99203	OFFICE/OUTPATIENT VISIT NEW	57.20	$57.20	---	$57.20	009	1	0	0.00	$0.00	Y
P	99203	OFFICE/OUTPATIENT VISIT NEW	5.72	$57.20	$62.41	--	052	0	1	0.00	$0.00	Y

Example: E&M Visit in an outpatient (POS 22) for a child

Procedure Code: 99203

Child Rate: $62.41

Cutback Indicator = 1

Medi-Cal/CalOptima Child/Cutback Rate: $62.41 - $12.48 (20 percent) = **$49.93**

Professional and Technical Components

Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %
L	70010	CONTRAST XRAY OF BRAIN	45.41	$173.47	---	--	005	0	0	0.39
L	70015	CONTRAST XRAY OF BRAIN	23.30	$89.01	---	--	005	0	0	0.39
L	70030	XRAY EYE FOR FOREIGN BODY	8.80	$33.62	---	--	005	0	0	0.31
L	70100	X-RAY EXAM OF JAW <4VIEWS	6.57	$25.10	---	--	005	0	0	0.33
L	70110	X-RAY EXAM OF JAW 4/> VIEWS	10.00	$38.20	---	--	005	0	0	0.33
L	70120	X-RAY EXAM OF MASTOIDS	6.80	$25.98	---	--	005	0	0	0.35
L	70130	X-RAY EXAM OF MASTOIDS	12.00	$45.84	---	--	005	0	0	0.33

- Prof % field is a percentage of the reimbursable rate of the professional component = mod 26.
- The balance percent is the reimbursable rate of the technical component = mod TC.
- A “0” in the Prof % field means not split billable.

Professional and Technical Components (cont.)

Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cutback Ind	Prof %
L	70010	CONTRAST XRAY OF BRAIN	45.41	$173.47	---	--	005	0	0	0.39
L	70015	CONTRAST XRAY OF BRAIN	23.30	$89.01	---	--	005	0	0	0.39
L	70030	XRAY EYE FOR FOREIGN BODY	8.80	$33.62	---	--	005	0	0	0.31
L	70100	X-RAY EXAM OF JAW <4VIEWS	6.57	$25.10	---	--	005	0	0	0.33
L	70110	X-RAY EXAM OF JAW 4/> VIEWS	10.00	$38.20	---	--	005	0	0	0.33
L	70120	X-RAY EXAM OF MASTOIDS	6.80	$25.98	---	--	005	0	0	0.35
L	70130	X-RAY EXAM OF MASTOIDS	12.00	$45.84	---	--	005	0	0	0.33

Modifier 26 = Professional Component

Modifier TC = Technical Component

Modifier ZS = Both Technical and Professional Components

Sample: Contrast X-ray of Brain — 70010

Medi-Cal/CalOptima Rate: 7001026 = $173.47 x 0.39 = **$67.65**

70010TC = $173.47 x 0.61 = **$105.82**

70010ZS = $67.65 + $105.82 = **$173.47**

Questions?

HEDIS

CCN Lunch and Learn

February 03, 2015

Mary Botts, RN

Manager, HEDIS and Data Analytics

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California's **Top-Ranked Medi-Cal Plan**

—NCQA's Medicaid Health Insurance Plan Rankings 2014–2015

HEDIS Overview

Healthcare **E**ffectiveness **D**ata & **I**nformation **S**et = HEDIS

- The most widely used set of health care performance measures for commercial, Medicare and Medicaid in the United States

- Developed and maintained by the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization committed to assessing, reporting on and improving the quality of health care

HEDIS Overview (cont.)

- National Committee of Quality Assurance (NCQA) defines HEDIS as “a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans.”
- HEDIS is one component of NCQA's accreditation
- HEDIS is the most used performance measure in the managed care industry.
- NCQA uses these measures for commercial, Medicare and Medicaid.

HEDIS Overview (cont.)

- Results from HEDIS data collection serve as measurements for quality improvement process and preventive care programs.
- HEDIS rates are designed to evaluate the effectiveness of a health plan’s ability to demonstrate an improvement in its preventive care and quality measures to plan’s 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 service.

HEDIS Measurement Period

- Data is reported to NCQA in June of the reporting year.
  - Data reflects events that occurred during the measurement year (calendar year).
  - HEDIS 2015 data is reported in June 2015; however, it reflects data from January to December 2014.
  - HEDIS 2015 = 2014 data

HEDIS Domains of Care

- HEDIS consists of 83 measures across five domains of care that address important health issues.
- HEDIS Five Domains of Care
  - Effectiveness of Care
  - Access/Availability of Care
  - Experience of Care
  - Utilization and Relative Resource Use
  - Health Plan Descriptive Information

HEDIS Obstacles

- Members are assigned to the wrong PCP or information is not properly transferred to the new PCP.
- Claims are submitted without the proper ICD-9 or CPT codes that count toward the measure.
- The provider specialty does not count for the measure.
- The member is not continuously enrolled.
- The services are not documented properly in the member's medical record.
- All components of the required measure were not met.
- Appointment availability
- Member perception of care

What is a HEDIS Measure?

- Clinical Measure — Calculates the percentage of members that receive a certain standard of care
  - Breast Cancer Screening (BSC) — The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
  - Antidepressant Medication Management (AMM) — The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.
    - *Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)*
    - *Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)*

What is a HEDIS Measure? (cont.)

- Survey Measure results summarize member (or parent) experiences through ratings, composites and question summary rates.
  - The Consumer Assessment of Healthcare Providers and Systems Program (CAHPS) included a myriad of survey products designed to capture consumer and patient perspectives on health care quality. NCQA uses the adult and child versions of the CAHPS Health Plan Surveys for HEDIS.
  - Surveys measure
    - **Effectiveness of Care:** Aspirin Use and Discussion; Tobacco cessation; Flu Shots; Pneumococcal Vaccination
    - **Experience of Care**: Getting Care Quickly; Getting Needed Care; Customer Service; How Well Doctors Communicate; Shared Decision Making; Rating of Personal Doctor/Heath Plan/Specialist/Overall Health Care

Data Collection

- Data Collection methodologies require that the health plan:
  - Identify the eligible population for the specific HEDIS measure through use of electronic records of service to include insurance claims and registration systems from hospitals, clinics, medical offices, pharmacies and labs; (denominator)
  - Determine the number of that population who are found to have received the service required for that measure. (numerator)
  - Calculate rates based on the above (numerator/denominator)

Data Collection Methods

- HEDIS measures are specified for one of three data collection methods:
  - Administrative
    - All data is electronic, submitted routinely, in a standard format.
    - All denominators are determined administratively. Criteria for some denominators is merely age and/or gender related. Other criteria requires evidence of a condition (e.g., diabetes).
    - Some measures use only electronic data to determine numerator (BCS, AMM).
  - Hybrid
    - Electronic data is used first to determine numerator.
    - If electronic data is not sufficient, we can supplement with medical records.
  - Survey
    - Surveys are conducted by an NCQA certified survey vendor.

Administrative Data

- All submitted claims and encounters (including pharmacy and vision services) received by December 20th are utilized for administrative data.
  - It is critical that ICD-9 codes and/or CPT codes approved by NCQA be submitted to ensure the member receives the necessary screening and the provider receives credit for performing the screening.
  - The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
  - See Code Reference Guide for appropriate ICD-9 and CPT codes regarding Hybrid measures for HEDIS 2015.
  - CalOptima will be reporting 77 measures between our Medi-Cal and OneCare populations that are Administrative only.

Hybrid Data Process

- As with the Administrative Data Collection Methodology, the denominator is determined with electronic data.
- A Statistical Sampling of approximately 411 Sample Members is selected for each Hybrid measure.
- If the Sample member results are negative electronically, medical records are used to verify whether or not the service was completed.
- CalOptima will be reporting 22 measures between our Medi-Cal and OneCare populations that are Hybrid.

Medical Record Collection

- NCQA deadline is very short and strict.
  - Medical record collection begins once the sample population is identified and approved by the NCQA certified auditors.
  - All medical record collection, abstraction, data entry and rate calculation must be completed by May 15th.
- CalOptima timeline
  - Submit approved sample population requiring medical record review to our record retrieval vendor by February 20th.
  - Vendor will reach out to providers the week of February 23rd.
  - Vendor will have all records to CalOptima by May 8th.

Medical Record Collection (cont.)

- CalOptima will be working with J&H Copy Service for HEDIS 2015.
  - J&H Copy Service has a Business Associate Agreement (BAA) with CalOptima and no further member release is required.
  - Providers will be contacted if they have provided services for a member in the sample population or are the member's PCP.
  - J&H will schedule a time to come to your office and scan records. Records may also be faxed or mailed if preferred.
  - J&H/CalOptima will be pursuing over 8,000 medical records.
  - Once received, the records need to be reviewed and the data entered into our HEDIS software.
  - Providers will be contacted if records are incomplete, illegible or if there are questions regarding the documentation.

Reasons for Negative Results

- We found that the most common reasons for a negative score across all measures are due to:
  - Lack of documentation in the medical record
    - No immunization flow sheet
    - No preventive health documentation sheet; No BMI
    - No diabetes flow sheet
    - No anticipatory guidance or health education noted
  - Lack of referral to obtain the recommended service
    - Diabetic retinal exam
    - HbA1c testing
  - HEDIS service received but outside of the recommended time frame.
    - Prenatal visit (1st trimester)
    - Postpartum visit (21–56 days after delivery)
    - Immunizations after the 2nd birthday

Reasons for Negative Results (cont.)

- Member non-compliance
  - Failure to follow physician advice
  - Lack of knowledge
  - Fear of test results
  - No-shows for scheduled appointments
- Missed opportunity
  - Consider any visit the last time you will see the member.
  - Sick child visit — if possible, do all components of a well visit.
  - Weight Assessment — had height and weight, but no BMI percentile calculated or graphed
  - Postpartum visit — a pap smear will also count for Cervical Cancer Screening — two measures at the same visit.
  - High Blood Pressure — repeat blood pressure later in visit
  - Current medications not reconciled to discharge medications during visit
  - No Advanced Care discussion during visit

- **PROOF is in the DOCUMENTATION!**

Can’t Make It All Go Away

- We appreciate your time and commitment to our members and understand that you are very busy.
- We also understand that CalOptima is not the only health plan requesting records, and that HEDIS is not the only project that requires records.
- We wish we COULD make it all go away — but since we can’t, here are some tips to help…

Avoid Medical Record Retrieval

- EMR and timely claims/encounters submissions
- Appropriate Coding
  - Code diagnoses to the appropriate specificity and include all procedure codes for services rendered.
  - Verify that you will be compliant with use of ICD-10 codes (required October 2015).
  - Verify your office is using current ICD-9 and CPT codes (e.g., your office does yearly review of superbills)
  - Use of CPT Category II codes
  - Refer to the CalOptima Coding Reference Guide for HEDIS 2015

Avoid Medical Record Retrieval (cont.)

- California Immunization Registry (CAIR)
  - Potential to submit files electronically to CAIR
  - If entering data manually, you can enroll online: http://cairweb.org/enroll-now/.
  - If you have an EHR, sending immunizations to CAIR can help the practice qualify for 'Meaningful Use' incentive payments.
  - CAIR can help with electronic billing for Medi-Cal beneficiaries.

Request Authorizations Early

- Request list of services that do not need authorization and request an authorization early if required, for example:
  - Diabetic Eye Exam — If member has retinopathy, a retinal exam is required every year, otherwise every two years.
  - Mammogram — every two years
  - Cervical Cancer Screening — every three years (or every five years if member is 30+ years old and HPV done on the same day)
  - Colorectal Cancer Screening — FOBT yearly; sigmoidoscopy every five years or colonoscopy every 10 years.

Be Prepared — Some Measures Just Need Medical Records

- Get ready
  - HEDIS is time sensitive, and the review period has been shortened in the past two years.
  - Assign one person to take requests and answer questions, if possible.
  - Don’t put it off — it truly won’t go away.
  - Inform the copy service if you have both EMR and paper records so they can get both in one trip.
  - Discuss the best time for calls and for scanning records.
  - Most frequently missed records — lab results. They are often kept in a separate area of an EMR or chart. Make sure the copy service knows where to find immunization forms, labs, consults, procedures (e.g., colonoscopy), etc.

Tools

CalOptima Provider Toolkit

- Divided into three sections:
  - Provider information for HEDIS
  - Clinical office tools and patient education
    - Age-specific documentation forms with anticipatory guidelines
    - Preventive services checklists, flow sheets, growth charts
    - Patient education handouts (English, Vietnamese, Spanish, Farsi, Korean)
  - Front office tools
    - Outreach materials
    - Resource materials
    - Cultural and linguistic tools (including cultural competency training)

(https://www.caloptima.org/en/Providers/ManualsPoliciesAndResources/ProviderToolkit.aspx)

Tools (cont.)

- If not using CalOptima exam forms included in the Provider Toolkit, update your exam forms to make sure they include all components of a well-care visit.
  - Health history
  - Physical developmental history
  - Mental developmental history
  - Physical exam
  - Health education and/or anticipatory guidance
  - Height and weight
  - BMI percentile for children and adolescents
  - BMI value for adults
  - Counseling for nutrition
  - Counseling for physical activity

HEDIS FAQs

- To learn more about HEDIS, please see the HEDIS Frequently Asked Questions document under the Provider FAQs heading on the page below
  - https://www.caloptima.org/en/Providers.aspx

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Questions?

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner


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