

# Provider Report™



## Take Advantage of Health IT Incentives

The federal economic stimulus law enacted in February will boost health information technology with \$17.2 billion in incentives available to physicians and hospitals that adopt electronic health records (EHRs). The bonus money will be paid through the Medicare and Medicaid programs from 2011 through 2016. The earlier the adoption, the larger the bonus. In brief:

- Medicare bonuses are paid once a qualifying EHR system is in place, with a maximum of \$44,000 paid over a four-year period of “meaningful use” of the system.
- Medicaid incentives include a year-one start-up grant of up to \$25,000 to help fund IT acquisition, with maximum annual bonuses of \$10,000 paid for four additional years of meaningful use.

Physicians who *don't* adopt EHRs will have their Medicare or Medicaid reimbursements progressively reduced: by 1 percent in 2015, 2 percent in 2016, and so on up to 5 percent.

Clarification of “meaningful use” is still to come from the Health and Human Services Secretary. It will spell out required capabilities, such as electronic prescribing.

Only 17 percent of U.S. physicians currently use EHRs, so reaching the Congressional Budget Office's projection of 90 percent adoption within five years is a major challenge. The ultimate goal of widespread EHR use is improved quality and efficiency, which is expected to result in significant, ongoing savings.

To review the programs and their requirements, check out David Blumenthal's recent article at [content.nejm.org/cgi/content/full/NEJMp0901592](http://content.nejm.org/cgi/content/full/NEJMp0901592). Blumenthal was just named National Coordinator for Health Information Technology by President Barack Obama.

## The Key to Successful EHRs

Sending reminders directly to patients leads to higher screening rates.

**A**re you wired and ready to go with electronic health records (EHRs)? Be sure to tap patients as a resource for your preventive agenda. A recent study published in *Archives of Internal Medicine* found that actively involving patients in the reminder process for screenings was more effective than reminding physicians only.

In the study, the EHR system of a multi-specialty group practice identified patients who were overdue for colorectal cancer screenings. The patients ranged in age from 50 to 80. One group of patients received mailed reminders. The second group of patients did not receive reminders; instead, their physicians received pop-up alerts when the patients' records were viewed. Overall screening rates were higher for the group of patients who received reminders directly, compared with the group whose physicians received the reminders. In the physician-reminded group, however, screening rates increased among patients with three or more primary care visits during the 15-month study period.

Snail-mail reminders work, but why not use health information technology to electronically connect with patients? Depending on your system, screening alerts generated by your EHR could automatically trigger e-mail reminders to patients and provide a link to an informational website on screening procedures.

Don't make assumptions about patients not being able to get on board the e-health bandwagon. The so-called digital divide has significantly narrowed. Recent studies show that patients from all socio-demographic groups are receptive to using interactive health IT; have benefited from it in terms of improved outcomes, convenience and lower costs; and have widespread access to the Internet through computers and mobile devices.



**Get Recognized for Making Connections** Would you like your practice to be recognized for its superior system that connects patients and doctors with information and with each other? Learn more about the National Committee for Quality Assurance Physician Practice Connections program at [ncqa.org/tabid/141/Default.aspx](http://ncqa.org/tabid/141/Default.aspx).

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# When Language Is a Barrier to Care

Individuals who speak little or no English need language-assistance services to help them access healthcare services and receive appropriate treatment. About 18 percent of Americans speak a primary language other than English at home. In Census 2000, about 8.4 percent of U.S. residents reported a limited English proficiency (LEP). But research shows that many U.S. hospitals fail to provide language assistance, in violation of federal antidiscrimination laws and Medicare and Medicaid requirements.

For LEP patients, the absence of language services may be life-threatening. They may not understand treatment instructions. Unable to adequately describe their symptoms to providers, they risk being misdiagnosed. They're three times more likely to experience adverse medical events than proficient speakers, the Joint Commission on Accreditation of Healthcare Organizations found.

In other research findings, LEP Americans tended to use fewer preventive care and public health services and relied less on primary

care. They were less compliant with medications and at greater risk of hospitalization. Language services can improve LEP patients' access to and navigation of the healthcare system and result in better outcomes and more cost-effective use of resources.

A majority of health professionals have cited cost as the biggest obstacle to providing language services, but according to a federal estimate, the added cost to provide interpreters for LEP patients would be an average \$4 per physician visit.

## CULTURAL COMPETENCY: PUT IT INTO PRACTICE

Any efforts to improve healthcare quality must incorporate cultural competency, which is the provision of equitable, patient-centered care across diverse populations. Despite widespread efforts to close racial, ethnic and cultural gaps, disparities persist:

- Cancer death rates among black men in 2007 are 33 percent higher than among whites—almost identical to rates reported in 1981.
- Although obesity-related chronic conditions are more prevalent among minorities, doctors were more likely to counsel obese whites than blacks and Hispanics about exercise.
- Compared with their white counterparts, older Hispanic and black adults are much less likely to be vaccinated against influenza and pneumococcal disease.

You can help to meet the cultural competency challenge in your practice with the help of a free online training tool from the Health Resources and Services Administration. "Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency" is a five-module course approved for CME credit. Visit [hrsa.gov/healthliteracy/training.htm](http://hrsa.gov/healthliteracy/training.htm).

The Sunshine State Health Plan's Cultural Competency Plan is located in the Provider Manual or can be reviewed at [www.sunshinestatehealth.com/portal/wcm/resources/file/eb01f3045322af4/2009\\_Cultural\\_Comptency\\_05-07-09.doc](http://www.sunshinestatehealth.com/portal/wcm/resources/file/eb01f3045322af4/2009_Cultural_Comptency_05-07-09.doc).

## CPT Category II Codes

CPT Category II Codes are supplemental codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows specific services, test results and other similar data to be captured at the time of service, thus reducing the need for retrospective medical record review.

Use of these codes is optional, is not required for correct coding and may not be used as a substitute for Category I codes. However, Sunshine State Health Plan encourages the use of these codes. Submission of these codes can minimize the administrative burden on providers by greatly decreasing the need for medical record review, particularly related to health plan HEDIS reporting.

The following are CPT Category II Codes applicable for HEDIS measures:

Hemoglobin A1c Levels	3044F, 3045F, 3046F, 3047F
LDL-C Levels	3048F, 3049F, 3050F
Nephropathy Screening Results	3060F, 3061F
Systolic B/P Levels	3074F, 3075F, 3076F, 3077F
Diastolic B/P Levels	3078F, 3079F, 3080F
Prenatal Care Visits	0500F, 0501F, 0502F
Postpartum Care Visits	0503F
Medication Reconciliation	1111F

## HOW WE MAKE UM DECISIONS

### Plan Affirmative Statement

Sunshine State Health Plan does not reward practitioners, providers or employees who perform utilization reviews, including those of the delegated entities. No one is compensated or otherwise given incentives to encourage denials. Utilization denials are based on lack of medical necessity or lack of covered benefit.

Sunshine State Health and its delegated health plan partners have utilization and claims management systems in place in order to identify, track and monitor the care provided and to ensure appropriate healthcare is provided to the members.

Sunshine State Health has implemented the following to ensure appropriate utilization of healthcare:

- A process to monitor for under- and overutilization of services and initiate the appropriate intervention when identified.
- A system in place to support the following processes:
  - Analysis of utilization statistics.
  - Identification of potential quality-of-care issues.
- Processes to implement intervention plans and evaluate the effectiveness of the actions taken.
- A process to support continuity of care across the healthcare continuum.

### Find These Topics in Your Provider Handbook

- How We Protect PHI (page 5)
- Medical Record Standards (pages 20–21)
- Availability of UM Criteria (page 30)
- Availability of Peer to Peer Discussion (page 30)
- Case Management (pages 31–35)
- Smart Start—Pregnancy Program (pages 33–34)
- Preventive Health and Clinical Practice Guidelines (pages 35–37)
- Review of New Technology (page 37)
- Information about Sunshine State Health's QI Program (pages 69–76)
- Member Rights and Responsibilities (pages 79–81)
- Preferred Drug List—Updated with Changes Annually (page 90)

Please call Provider Services at 1-866-796-0530 for Right to Information About Status of Credentialing or Recredentialing Application.

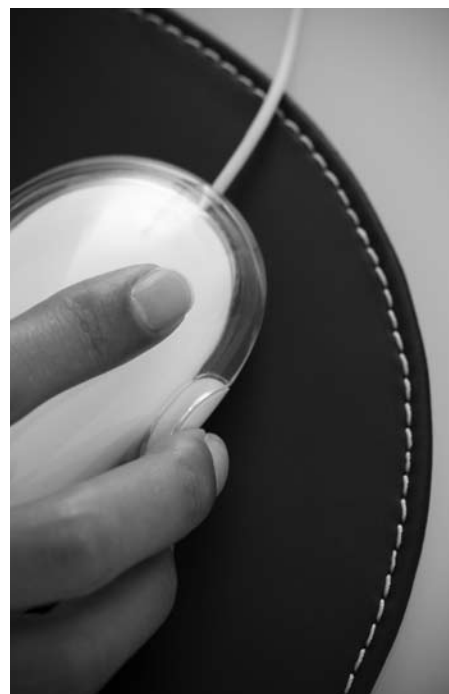
You can also read about these topics on our provider webpage at [www.sunshinestatehealth.com](http://www.sunshinestatehealth.com). **IF YOU DON'T HAVE ACCESS TO A COMPUTER OR YOU HAVE LOST YOUR PROVIDER MANUAL, PLEASE CALL PROVIDER SERVICES AT 1-866-796-0530.**

### Appointment Availability Standards

Sunshine State Health Plan has established the appointment availability standards below to ensure reasonable access to care for patients:

- Urgent Care—within one (1) day.
- Routine Sick Patient Care—within one (1) week.
- Well Care Visit—within one (1) month.
- After hours: Answering service, call forwarding, provider call coverage or other customary means—must return the call within thirty (30) minutes of the initial contact.

For additional information, please see page 10 in the Provider Manual or our provider webpage at [www.sunshinestatehealth.com](http://www.sunshinestatehealth.com).



### Website Information For Providers

The provider pages of Sunshine State Health Plan's website offer an array of tools to help you manage your business needs and access information of high importance to you, including patient eligibility listings, search functions for providers, and tools for submitting and checking the status of claims.

All contracted providers should visit [www.sunshinestatehealth.com](http://www.sunshinestatehealth.com) to register and create a username and password so you can begin using the available services. Doing so will give you access to items like:

- Enhanced member eligibility verification, including enrollment history.
- Improved claims review with detailed information regarding claims status.
- Updated online prior authorization.
- Updated online claims submission

For more information about our website or for questions about enrolling, please call our Provider Services Department at 1-866-796-0530.

# Diagnosis: Incentive to Change

Patients make dramatic lifestyle changes when told they have a chronic disease.

**T**urn a negative into a positive. From lemons, make lemonade. Spin crisis into opportunity. To those upbeat life instructions, add this one: Use sickness as a wake-up call for healthy change.

A study of middle-age and older adults found that smokers newly diagnosed (within the past year) with heart disease, diabetes or another serious condition were three times more likely to kick the habit, compared with smokers who received no new diagnoses, according to results published in the *Archives of Internal Medicine*. Smokers diagnosed with more than one serious illness were six times more likely to quit.

The study also found that a new diagnosis was associated with weight loss among overweight or obese adults. Among those newly diagnosed with lung disease, heart disease or diabetes, body mass index (BMI) decreased by

an average of 0.34 units. They lost an average of 2 to 3 pounds more than their counterparts who had no new diagnosis. Those with multiple diagnoses lost an average of 0.64 units.

Data analyzed came from the Health and Retirement Survey, which collected health information on middle-age and older adults (up to age 75) every other year over a period from 1992 through 2000.

New diagnoses may heighten patients' motivation to change unhealthy habits. Although many providers address lifestyle changes with patients during treatment for chronic conditions, **the study findings suggest timing the lifestyle-change counseling to the diagnosis to achieve the maximum effect.**

One reason smokers in the study may have had such dramatic results is that there's more help available for smokers who want to quit. Smoking-

cessation programs are covered by many health insurance plans and are often offered at low or no cost through employers or local health organizations. This is not the case for weight-loss programs—although this is beginning to change as obesity is recognized as a public health crisis and employers experience lost productivity and rising healthcare costs. Effective weight-loss interventions require ongoing monitoring, and few primary care physicians have the time or resources to provide such services.

An editorial accompanying the study findings notes that “the effect of physician advice might only be as good as the availability of supportive services to which patients can be referred for specialized preventive care. Our healthcare system is incomplete to the extent that patients and healthy subjects do not have affordable access to evidence-based preventive services.”

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