

MISSION STATEMENT

Delaware Physicians Care, an Aetna Health Plan, strives for value, integrity and compassion in health care management and consulting.

VISION

The vision of Delaware Physicians Care, an Aetna Health Plan, is to be recognized as the nation's foremost managed care resource by providing the highest value management and consulting services throughout the health care continuum.

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252 Chapman Road, Suite 250
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Claims Inquiry
Please call 1-866-543-2167.
Select option #2 for provider, then
select option #1 for claims department.

Editor - Chris Byrom

2011 HEDIS®/CAHPS® Health Plan Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program covers a range of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and accessibility of services.



The National Committee for Quality Assurance (NCQA) uses the Health Plan CAHPS® survey in its Health Plan Accreditation Program as part of the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® measures health plan performance on important dimensions of care and service and is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans.

Delaware Physicians Care's 2011 HEDIS®/CAHPS® Health Plan Survey results are in and the scores are great! Members' satisfaction with their health care and health plan are higher. For all NCQA reported composite measures, Delaware Physicians Care scored in the 75th percentile or higher. We would like to thank our provider network for their efforts in helping us achieve such high marks in the 2011 HEDIS®/CAHPS® Health Plan Survey.

Our goal for 2012 will be to have all reported CAHPS® composite measures score in the 90th NCQA percentile. To achieve this goal, we will be focusing on improving the following composites:

- **Adult CAHPS® Survey Composite** – Rating of Personal Doctor
- **Child CAHPS® Survey Composites** – Getting Care Quickly and How Well Doctors Communicate

As part of our continuous quality improvement process, we will be work on developing member and/or provider focused interventions and information to help raise scores in these areas. Information on our activities will be communicated throughout the year. We thank you in advance for your time and assistance in moving our 2012 CAHPS® scores towards our goal.

Diabetes Self-Management Program

A Stanford Self-Management Course developed by Dr. Kate Lorig

The Delaware Division of Public Health's goal is to decrease the State's emotional, physical, and financial burden from diabetes by preventing the disease and reducing its complications. Providers interested in holding Diabetes Self-Management Program classes are invited to register below.

About the program

- The Diabetes Self-Management Program teaches the skills needed in the day-to-day management of diabetes and to maintain and/or increase life's activities.
- The program is designed to help gain self-confidence with the ability to control symptoms and learn how health problems affect one's life.
- The workshops are highly interactive, focusing on building skills, sharing experiences and support.
- The small-group workshops are six weeks long, meeting once a week for about 2.5 hours and are led by two Lay Leaders.
- The program will help teach how to identify and solve problems.
- The program is brought to you at no cost by the Delaware Division of Public Health.



We are looking for community people who

- Have type 2 diabetes.
- Are committed to attend six – 2.5 hour workshops.
- Are interested in helping improve quality of life while living with type 2 diabetes.
- Want to learn how to take control and self manage diabetes.

Class objectives

- Prevent and delay complications.
- Understand the importance of communication.
- Improve A1c (quarterly blood sugar reading).
- Understand the importance of an action plan.

Subjects covered

- Techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration.
- Appropriate exercise for maintaining and improving strength and endurance.
- Healthy eating.
- Appropriate use of medication.
- Working more effectively with health care providers.

Participants will make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their diabetes self-management program.

It's Time to Take Control of Diabetes! Questions? Please call Tené at 302-894-6818



THANKS again to the level of care and service you and your staff provide to our members; 58.42% of our Healthcare Effectiveness Data and Information Set (HEDIS®) results improved from 2010 to 2011.

Of the 93 measures analyzed with percentiles, we were able to:

- Sustain 10.8% of the measures above the 90th percentile;
- Increase measure scores above the 75th percentile (considered best in class) by another 14.7 % for such indicators as the “weight assessment and counseling for nutrition and physical activity for children and adolescents”; and
- Report 86.87% of the measures scoring greater than or equal to the national average.

HEDIS® is the backbone of quality and service clinical programs at Delaware Physicians Care. In July 2011, we implemented the Primary Care Provider Panel Wellness Tool as confirmation of the excellent care that our members receive through our large network of primary care providers. The goals of this initiative are to:

- Assist our providers in simplifying care for our members; and
- Identify opportunities for improvement in the delivery of primary care services through utilization of HEDIS® measures and standards of care included in the Patient Centered Medical Home Model.

Jessica Jamelkowski, Healthcare Quality Consultant, along with provider relations, has been reaching out to discuss and educate providers and staff about the HEDIS® measures of focus and how we work together to create healthier outcomes for the population we serve:

- Adolescent Well Care
- Antidepressant Medication Management (Acute and Continuation)
- Appropriate Treatment for Children/Upper Respiratory Infection
- Appropriate Testing for Children/Pharyngitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Lead Screening
- Use of Appropriate Asthma Medications
- Comprehensive Diabetes Care-HbA1c Testing
- Comprehensive Diabetes Care-LDL Screening
- Comprehensive Diabetes Care-Dilated Retinal Eye Exam
- Children's Access/PCP

Primary care providers receive both the individual Physician Quality Measurement Report and the Patient Wellness Detail Report reports on a quarterly basis. The **Physician Quality Measurement Report** summarizes measurement ratings for a provider's entire panel (inclusive of every member assigned to that provider no matter at which location they are seen). It provides an individual rating in each measure as well as comparison rates to the plan as a whole and the NCQA Medicaid 75th percentile and reports information in both text and bar graph formats. The **Patient Wellness Detail Report** provides a detailed listing of each Delaware Physicians Care member in their panel who are still in need of care or services for the remainder of the year.

We are testing the provider web portal to enable physicians the ability to pull their detail reports directly in the 1st Qtr 2012.

For additional information about our Primary Care Provider Panel Wellness Tool, please call Jessica at 302-894-6759.

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Electronic Funds Transfer

Delaware Physicians Care encourages providers to enroll for Electronic Funds Transfer (EFT) for electronic payments. EFT is safe, secure, efficient and less expensive than paper check payments. Providers can complete the EFT enrollment form at:

http://www.DelawarePhysiciansCare.com/pdf/EFT_Authorization_Enrollment_Form_Delaware.pdf

Please contact your provider relations representative if you have any questions about enrolling.

Evaluation and Management – Levels of Service

The intent of this article is to provide a basic overview of Evaluation and Management (E/M) coding and describe the process used to determine the level of service focusing primarily on the three key components: history, exam and medical decision making.

E/M services are the foundation of physician services encompassing approximately one-third of all charges reported to third party payers. E/M codes represent the provider's evaluation of the patient's condition and management of the patient's care. The goal in coding E/M services should be to always report services at the highest level of specificity and accuracy and to ensure that documentation always supports the service reported.

Per American Medical Association (AMA) Current Procedural Terminology (CPT), there are seven components whose selection determines the overall level of service. These are:

- History
- Exam
- Medical decision making (MDM)
- Counseling
- Coordination of care
- Nature of the presenting problem
- Time

The first three of these components are referred to as the **key** components in selecting level of service. Components 4-7 are considered contributing factors.

The first step in selecting the appropriate level of service (LOS) and ultimately the correct E/M code, is to identify the key components of the E/M service from the documentation. Key components are a factor in assigning all E/M codes where there is a choice in the level of service provided. For example, categories within the E/M section of CPT where a code range is available wherein each code demonstrates an incremental increase in severity or complexity of the service provided based on the extent of the history, exam, or medical decision making, such as with 99201-99205.

While history and exam documentation are very important pieces in choosing an E/M level of service, the overriding concept in choosing a level of service is medical decision making. The more complex a problem is, the higher the degree in difficulty will be; taking into consideration evaluation, diagnosis and treatment options. Complete history and exam documentation given in conjunction with a self-limited, minor problem would not justify the medical necessity of reporting a higher level of service.

Five levels of service are recognized by the CPT codes for both the new or established patient office visits. There are three key components in determining the correct level of E/M service. These components are: *history, examination, and medical decision making*. The following documentation guideline examples for 99211, 99212 and 99213 outlines the level of medical necessity and documentation appropriate for reporting of each level.

Examples:

Summary of documentation requirements for a level 1 established patient: 99211

Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

This E/M services is unique from all others. There are no key component indicators listed; the CPT definition also states this service may not require the presence of a physician. This service is most typically billed for nurse-only services; documentation should support whatever interaction transpired between the patient and the nurse.

Summary of documentation requirements for a level 2 established patient visit 99212

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A problem focused history
 - Brief HPI -1 to 3 elements of history of present illness
 - No Review of Systems Documents
 - Past/Family/Social History documented
- A problem focused examination;
 - Limited examination of the area in question
- Straight-forward medical decision making.
 - Number of diagnoses/management options - Minimal (one self-limiting, stable problem)
 - Amount/Complexity of Data to be Reviewed - Minimal or None (tests with no significant risk associated like lab requiring venipuncture or EKG)
 - Risk of Complication/Morbidity/Mortality - Minimal (treatment options include rest, superficial bandages)



Summary of documentation requirements for a level 3 established patient visit 99213

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- An expanded problem focused history
 - Brief HPI -1 to 3 elements of history of present illness
 - Problem Pertinent Review of Systems Documented-ROS for the one system directly related to the chief complaint
 - No Past/Family/Social History documented
- An expanded problem focused examination
 - Limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
- Medical decision making of low complexity.
 - Number of diagnoses/management options - Limited (two minor problems/one stable chronic illness/acute uncomplicated illness)
 - Amount/Complexity of Data to be Reviewed - Limited (such as physiologic testing not requiring stress, superficial biopsy)
 - Risk of Complication/Morbidity/Mortality - Low (such as over-the-counter drugs, therapy, minor surgery with no identified risk factors)

E/M level of service coding is always driven by two factors: medical necessity and actual documentation provided by the provider. Selecting a level of service driven by medical necessity and then providing the appropriate documentation to support the service is the key to compliance and reimbursement.

References:

1995 AMA/CPT Documentation Guidelines: www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf

1997 AMA/CPT Documentation Guidelines: www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf

Split Surgical Care

Split surgical care occurs when different physicians furnish either the pre-operative, intra-operative or post-operative portions of the global surgical package. Split surgical care is only applicable to providers of different Tax ID groups or providers within the same Tax ID group but with different specialties. Providers within the same Tax ID group and same specialty are treated as a single entity and may not bill split surgical care.

When split surgical care occurs, each provider is reimbursed according to the portion of surgical care they provided. The three portions of surgical care are:

- Pre-operative
- Intra-operative - surgical care only, including hospital post-operative care
- Post-operative

Centers for Medicare & Medicaid Services (CMS) has established percentages for each of the three portions of surgical care for all 10-day and 90-day procedure codes. These percentages are located on the National Physician Fee Schedule Relative Value file (NPFSSRV), which is updated quarterly by CMS. The sum of these portions represents the total global surgical package.

Split Surgical Care - Modifiers

According to the AMA CPT Manual, the following modifiers should be used by the billing provider to indicate which portion of the global surgical practice was provided:

Modifier 54 – Surgical Care Only

Modifier 55 – Post Op Management Only

Modifier 56 – Pre Op Management Only

Split Surgical Care - Things to Know

- According to American Medical Association (AMA) Current Procedural Terminology (CPT), descriptions for modifiers 54 (Surgical care only), 55 (Post-op management only), and 56 (Pre-op management only) indicate that they are surgical in nature and therefore should not be appended to a non-surgical procedure code (a non-surgical procedure code is defined as any service with a zero-day global period or when the global concept does not apply).

- Split surgical care can only occur when the physicians involved have formally (i.e. in writing) transferred the care of the patient from one physician to another. The transfer of care may be in the form of a letter or an annotation in the hospital or ASC record. If a formal transfer of care has not occurred, then it is appropriate for the physician, other than the surgeon, providing the post-operative care to bill with Evaluation and Management services.

- The provider that rendered the surgical care only should append modifier 54 (Surgical Care Only) to the surgical procedure code. Unless another provider has billed separately for the pre-operative care (modifier 56), it is assumed that the provider billing modifier 54 has rendered the pre-operative care, the intra-operative care and the post-operative hospital care and will thus be reimbursed at the pre-operative and intraoperative percentages.

- Providers billing modifier 55 (Post-Operative Care Only) or modifier 56 (Pre-Operative Care Only) should:

- Use the same procedure code that was billed by the surgeon (modifier 54).
- Use the actual surgery date, even though they may not have seen the patient for a period of time after the surgery.

Appropriate use of split surgical care modifiers helps to clarify what services were performed and aid in proper adjudication.

HIPAA 5010

Effective January 1, 2012, Delaware Physicians Care will only accept 5010 compliant electronic transactions. Physicians who submit claims electronically will be required to use a street address or physical location as the provider address under 5010 transactions. Reporting a P.O. Box in the billing provider address field will cause claims to be rejected. Practices that wish to continue having payments sent to a P.O. Box or lock box will report this address in the "pay to" address field. Practices will need to work with their practice management system vendor, billing service, or clearinghouse to have the address change made for claims.



Top 3 Appeal Reasons

In an effort to facilitate a better understanding for our provider offices of the predominant types of provider appeals received by Delaware Physicians Care, we would like to share the top 3 reasons for provider appeals.

1. **High Tech Radiology Denials** - MedSolutions processes all outpatient prior authorization requests for high tech radiology. Please remember to request authorization from MedSolutions prior to rendering service.
2. **Elective/Cosmetic Surgery Denials, e.g., breast reductions** – Please remember to check the Prior Authorization Research Tool for all covered codes and codes that require prior authorization.
3. **Specialty Pharmacy Drug Denials** - Please review the list of drugs that are provided through the specialty drug program. The complete list of drugs and authorization forms can be found at <http://www.DelawarePhysiciansCare.com/Providers.aspx>.

Clinical Policy Bulletins - Obtaining Medical Criteria

Delaware Physicians Care utilizes evidence-based, nationally recognized criteria to make coverage determinations. Copies of the criteria, protocols or guidelines utilized to make specific case review decisions are available to members, member authorized representatives and providers upon request.

To request a copy of the criteria, protocol, or guideline please call 1-866-642-1592, **prompt 9**.

Copies of Aetna Clinical Policy Bulletins are available online at http://www.aetna.com/cpb/cpb_menu.html.

Recent Delaware Physicians Care Member Notices

Delaware Physicians Care is committed to keeping our members informed with important information about their health plan, member rights and responsibilities, and any new or updated benefits or services required under State and Federal regulations or by accrediting bodies.

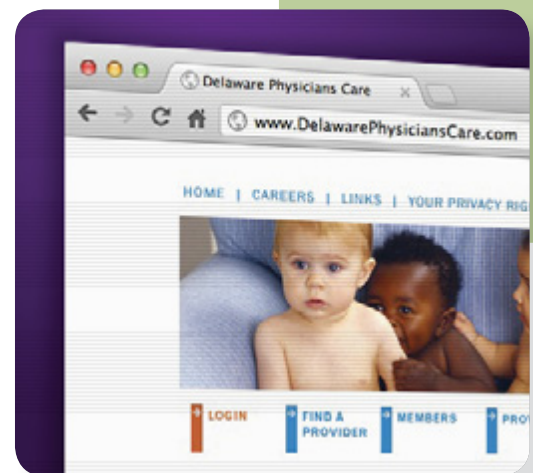
We would like to share with you three articles recently published in the Fall/Winter 2011 edition of our member newsletter, *HealthAware*.

Member Rights & Responsibilities

As a Delaware Physicians Care member you have rights and responsibilities. You can use all of your member rights without being treated differently. You can use all of your member rights without losing any health care services.

It is important to know and understand your rights and responsibilities. They are listed in your Member Handbook. They are also listed on our website. Go to www.DelawarePhysiciansCare.com. Click on the Members page, and then click on Member Rights & Responsibilities.

If you have any questions about your rights and responsibilities, please call Member Services toll free at 1-866-543-2167.



A Note to Our Female Members

Medicaid law says that women must have direct access to women's health providers for routine and preventive health care services.

Some of these services are

- Prenatal care
- Breast exams
- Mammograms
- Pap tests

Direct access means you do not need a referral or an OK from us to get routine and preventive services from a participating women's health provider.

One type of women's health provider is a GYN doctor (gynecologist). Female members may see any of our providers for routine and preventive health care. A referral or OK from us is not needed.

Quality Management at Delaware Physicians Care

Delaware Physicians Care has a Quality Management department. We offer many health programs. We focus on making education, access and services better for our members.

The department looks at the care members get. It has programs that teach members how to live healthy lives. Our Prevention & Wellness staff are in the community talking to children and adults about being healthy.

The department also tracks Delaware Physicians Care activities. It checks to make sure members can get safe care and services. Some of the ways we do this are:

- Prevention & Wellness outreach
- Quality improvement projects: prenatal care, emergency room use, asthma and diabetes self control
- Quality audits
- HEDIS® measures (HEDIS® stands for Healthcare Effectiveness Data and Information Set)

HEDIS® is a tool that rates how well doctors are doing. It looks at:

- Well-child visits
- Shots given on time
- Pregnancy visits
- Eye exams for members with diabetes

We got higher HEDIS® rates in 2011 than in 2010 for most areas. We met or scored higher in over half of our HEDIS® measures. Over the past three years, more pregnant women are getting timely doctor visits. Also, well child visits for those 12-17 years of age went up. And, counseling for nutrition for those 3-11 years of age also went up.

We also look for problems with the way care is given to our members. We make sure that each member gets safe care and the care they need.

Call Member Services toll-free at 1-866-543-2167 to find out more about our quality programs. We can send you a written description of our Quality Management program.

