

health **MD** matters

Health Plan of San Mateo Provider Newsletter

Fall 2010

From the Desk of the Medical Director Using Phone Triage to Meet Timely Access Regulations

In our spring newsletter, we informed you about the new state regulations to improve patient waiting times for medical appointments. The Department of Managed Health Care (DMHC) requires managed care providers to ensure patients get in to see a doctor in a timely way, depending on the urgency of their medical need.

This month, I want to focus on how to implement a specific requirement of this regulation: using phone triage or screening to respond to patient requests for an appointment. In order to meet the rules surrounding this requirement, our physicians may need to make adjustments to their office processes.



What are the new rules for phone triage?

We know that physicians and their office staff already perform triage and screening throughout the day. However, DMHC has defined the following rules for performing triage or screening:

- Phone triage or screening services must be available 24/7.
- A return call must be made within 30 minutes.

- The person doing the triage or screening may be unlicensed; however, any person making a determination about when a patient needs to be seen for an appointment must be a licensed medical professional.

We want to assure you that these are not Health Plan of San Mateo rules. They are state rules that every

[more on page 2](#) ➔

In this issue:

3 Changes for submitting
CareAdvantage claims

4 Talk to patients
about breastfeeding

6 Child well visits:
Learn about incentives

 **HealthPlan**
OF SAN MATEO

Using Phone Triage to Meet Timely Access Regulations

► continued from cover

health plan in California will be required to follow. Therefore, your contracts with other health plans will require compliance with the timely access rules as well.

The important details for compliance

You must have telephone triage or screening services available 24/7.

After hours. You must meet *one* of the following requirements:

- You have a nurse advice line with licensed staff making recommendations for care.
- You have an answering service that pages a physician, and the physician answers within 30 minutes.
- You have an answering machine or cell phone voice mail with a message that states that if the caller has an emergency, he or she should call 911 or go to the nearest emergency room; otherwise, the caller should leave a message and expect a return call within 30 minutes.
- You have a physician who can be paged and who will respond to messages within 30 minutes.

If one of the above options is already in place, you are covered.

During office/clinic hours. Staff



members answer the phone, collect information (if they are not licensed), and have a physician or another licensed staff member review it to determine when the patient needs to be seen. Then, the patient needs to be called back within 30 minutes.

If you use an answering machine at any time during the day:

- Messages need to be checked regularly, so that calls can be returned within 30 minutes.
- It has to convey the same message used during after hours.

No 'waiver' during lunch breaks

If your staff takes a lunch break for 60 to 90 minutes and uses an answering service or answering machine, calls from patients still need to be returned within 30 minutes. The regulation does not exempt lunch hours from the 30-minute response time.

Solo or small group practitioners

It may be helpful to speak with some of your fellow physicians about working as a group to use an answering service or a nurse advice line, when your office is busy during the day during lunch hours or after hours. This is one way to ensure meeting the rules for triage timeliness. There are probably other solutions that you can develop as well. Hopefully, all of these possibilities will result in the aim of the regulations: to achieve improved access for all health plan members.



Mary Giammona, M.D.

Change Coming in 2011: CareAdvantage Claims

Effective January 1, 2011, Medicare claims must be submitted within one year from the date of service, according to a new rule from the Center for Medicare & Medicaid Studies.

All CareAdvantage claims must be submitted to Health Plan of San Mateo (HPSM) within 12 months

from the date of service in order to qualify for the full approved payment amount. Claims received after 12 months will be denied.

If you have any questions about this change, please call our Claims CareAdvantage Development Unit at **650-616-2137** or HPSM's Claims Department at **650-616-2056**. ■

HPSM will need to receive claims within 12 months.

Coming Soon to HPSM in 2011: HEALTHsuite

The Health Plan of San Mateo is excited to announce its future transition to a new claims and benefit system. HEALTHsuite is a fully integrated claims processing system that streamlines and simplifies health care business processes.

Key benefits will include:

- Electronic claims and authorizations submissions

- Online eligibility verification

More information will be available in late 2010. Look for more details in our winter newsletter and on our website.





Encourage Mothers to

Regina Benjamin, M.D., U.S. surgeon general, states in her report *The Surgeon General's Vision for a Healthy and Fit Nation*: "The first decision that parents make about what to feed their child occurs during pregnancy.... Beginning early in life, breastfeeding is a relatively short-term intervention which has significant long-term potential for maintaining a lower BMI."¹

Further, medical studies have found that the likelihood of obesity is 22 percent lower among children who are breastfed.²

San Mateo County's WIC Program (Special Supplemental Nutrition Program for Women, Infants, and Children) has made consistent strides since 1995 toward supporting breastfeeding and promoting exclusive breastfeeding. The program's efforts have contributed to the county's success in surpassing the Healthy People 2010 goals for the breastfeeding initiation rate of at least 75 percent and the six-month exclusive breastfeeding rate of 17 percent.

However, there is still room for improvement in sustaining exclusive breastfeeding rates through the first six months. Our county's rate for exclusive breastfeeding at enrollment to WIC is 80.6 percent, but it quickly falls to 32.6 percent at two months

Breastfeed *It Can Make a Difference in Preventing Obesity*

and 17.9 percent at six months.

WIC continues to promote exclusive breastfeeding by offering the following services to support mothers of newborns and infants:

- Prenatal breastfeeding education
- Breastfeeding peer counselors
- Breastfeeding phone support
- One-on-one consultations
- Mom and baby support groups
- Baby weight checks
- Electric breast pump loan program for exclusive breastfeeding mothers who work

How can providers help?

The Centers for Disease Control and Prevention has recommended increased support for breastfeeding, promotion of exclusive breastfeeding and worksite accommodations to pump human milk.³

Mothers of newborns need to consistently hear from their health care providers that it is in the best interest of both the mother and the baby to breastfeed. This should be done exclusively for as long as possible until the child is ready to eat food.

Whenever you see a pregnant woman in your office, whether at a prenatal visit or for another reason, offer encouragement to support the

mother's decision to breastfeed. Let her know that you're glad she has decided to breastfeed her baby. Tell her that breastfeeding:

- Helps keep her baby healthy and prevent childhood obesity
- Reduces the risk of breast and ovarian cancers
- Saves the family money
- Creates a strong bond between mother and child

Encourage moms with newborns to call the WIC Breastfeeding Help Line at **800-205-0333**. The help line

offers advice about breastfeeding and provides support. ■

¹ U.S. Department of Health and Human Services, The Surgeon General's Vision for a Healthy and Fit Nation, U.S. Department of Health and Human Services, Office of the Surgeon General, Rockville, MD, January 2010, pp. 4, 6.

² S. Arenz et al., "Breast-feeding and childhood obesity—a systematic review," *Int J Obes Relat Metab Disord*, Vol. 28, No. 10, October 2004, pp. 1247-1256.

³ L. Khan et al., "Recommended community strategies and measurements to prevent obesity in the United States," *MMWR*, Vol. 58, No. RR-7, 2009.





Get Reimbursed for Child Well Visits: 3- to 6-year-olds

Medi-Cal Members Only

Health Plan San Mateo (HPSM) wants to reimburse providers and reward parents of child members for scheduling annual checkups for 3- to 6-year-olds. Busy parents need to be reminded that their healthy child needs an annual checkup to stay healthy. And we know that providers and their staff can use some assistance with keeping track of which pediatric patients are due for checkups. This is why we are pleased to offer the following incentives to help providers and parents follow up on our reminders.

Parents: Exchange checkup confirmation for Target gift card

We have started to mail birthday postcards to parents reminding them to schedule their child's annual well visit. Lately, you may have noticed

parents of 3- to 6-year-olds starting to bring these postcards from HPSM for you to sign. Your signature or office stamp confirms that you have seen their child for a well visit. Parents who return this self-mailer to us will receive a \$15 Target gift card.

Medi-Cal providers: Receive reimbursement for completing checkups

You will be reimbursed \$90 for completing an annual well exam for Medi-Cal members ages 3 to 6 years old. To help you identify our members who are due for their checkups, your quarterly HPSM Pay for Performance report will include a list of 3- to 6-year-old Medi-Cal patients who have not received an annual well visit. We encourage you to call their parents or guardians to schedule a well visit appointment. ■

Components of a Complete Well Exam

Assessment of interval history

This details what has occurred since the previous well visit with an evaluation of physical, behavioral and emotional growth and development. This includes:

- A physical exam
- Age-specific anticipatory guidance
- Completion and review of the Staying Healthy Assessment Tool for the appropriate age

Billing guidelines

To receive reimbursement, you must bill with the appropriate CPT code and one of the associated ICD-9 codes below:

CPT code

- 3 to 4 years:
 - 99382 for new patients
 - 99392 for established patients
- 5 to 6 years:
 - 99283 for new patients
 - 99393 for established patients

ICD-9 code

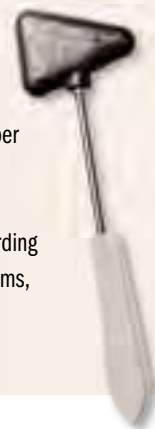
- V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Use the appropriate codes when billing to ensure that you get reimbursed correctly.

It also helps us track the number of 3- to 6-year-olds who are getting their annual well visits.

If you have any questions regarding billing and payment of well exams, please call Nicole Ford at

650-616-2169.



P4P

Update on Incentives and Diabetes Care

Thanks to the continued participation of our dedicated Medi-Cal primary care physicians (PCPs) and obstetricians, the P4P (Pay for Performance) program at Health Plan San Mateo (HPSM) has been a great success! Since it began in 2008, we have seen various quality measures improve. Nonetheless, we continue to refine the program to meet the needs of our providers and members, and we are pleased to add the following two new provider incentives.

New incentive for women's health exam

You will receive \$90 for doing a women's health exam for our Medi-Cal members ages 20 to 64. This includes vaginal cancer screening and pelvic and clinical breast exams. The reimbursement is paid annually for all eligible members. Submit a bill to HPSM with procedure code G0101 to receive your payment. We appreciate the dedicated time and staff that is necessary to perform a women's health exam.

New incentive for child well visit

You will receive \$90 for completing an annual checkup for our Medi-Cal

members ages 3 to 6 years. For details on the components of a child well visit and how to bill for reimbursement, see the articles on the facing page.

New, less stringent goal for adult Hb A1C incentive: < 8%

You will receive \$65 for each Medi-Cal member with controlled hemoglobin A1C (Hb A1C) levels under 8 percent. We changed the previous Hb A1C incentive range (under 7 percent) because of results from three large trials that revealed a substantially increased risk for hypoglycemia

with intensive Hb A1C control, without significant reduction in cardiovascular disease outcomes.^{1,2,3}

According to the American Diabetes Association, less stringent Hb A1C goals than the general guideline of under 7 percent may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced cardiovascular complications or extensive comorbid conditions.⁴ Please consider the risk of hypoglycemia as you assist our members with setting and reaching their glycemic control goals.

Diabetes lab data acquisition

We have successfully established data transfer relationships with many of the local private and hospital

▶ [more on back page](#)



For a good reason to encourage mothers to breastfeed, turn to page 4. ►

Outcomes Improve, New Incentives and Diabetes

► continued from page 7

laboratories to collect diabetes test results for our members. This enables us to automatically receive regular test and results data to render the appropriate diabetes incentives to PCPs. We are currently receiving diabetes lab data directly from San Mateo Medical Center, Quest Diagnostics laboratories, Seton Medical Center and Sequoia Hospital, and we are diligently working to get lab data from other hospital and private outpatient labs. We hope to start receiving data from

Mills-Peninsula Hospital and Stanford Medical Center by the end of this year. ■

¹ ADVANCE Collaborative Group, "Intensive Blood Glucose Control and Vascular Outcomes in Patients with Type 2 Diabetes," *N Engl J Med*, Vol. 358, No. 24, June 12, 2008, pp. 2560-2572.

² VADT Investigators, "Glucose Control and Vascular Complications in Veterans with Type 2 Diabetes," *N Engl J Med*, Vol. 360, No. 2, January 8, 2009, pp. 129-139.

³ ACCORD Study Group, "Effects of Intensive Glucose Lowering in Type 2 Diabetes," *N Engl J Med*, Vol. 358, No. 24, June 12, 2008, pp. 2545-59.

⁴ American Diabetes Association, "Standards of Medical Care in Diabetes—2010," *Diabetes Care*, Vol. 33, No. Supplement 1, July 2010, pp. S11-S61.

P4P online portal coming in 2011

P4P continues to be a dynamic program. We are working on streamlining some of the administrative requirements by launching an online P4P Provider Portal in 2011. The portal will allow you to access your P4P reports and submit forms online for the BMI incentive. This will assist you in earning and tracking your P4P incentive payments.

If you have questions or comments regarding the P4P program, please contact Nicole Ford at **650-616-2169**.

