

News and updates from Community Health Plan to network providers

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## Colorectal cancer screening

Patient awareness of the need for colorectal cancer screening is growing. However, there is still a minority of patients who will initiate requests for colorectal cancer screening tests or referrals for evaluation. Discussion of colorectal screening procedures is a sensitive and embarrassing topic for many patients and accompanies a high fear factor related to the possibility of a cancer diagnosis. Physicians therefore play a key role in raising patient awareness and making sure that their patients receive appropriate screening tests. For adults age 50 and older, primary care clinicians should assess the colorectal cancer screening status of each patient and discuss the range of options for appropriate screening. This should occur as part of the patient's annual health exam and with episodic care visits (non-emergent).

2007 was the fourth year for Healthcare Effectiveness Data and Information Set (HEDIS®) measurement reporting for the percentage of adults, age 50 to 80 years, who have received appropriate screening for colorectal cancer.

The screenings counted in this measure include:

- Fecal occult blood test (FOBT) during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years prior
- Double contrast barium enema during the measurement year or the four years prior
- Colonoscopy during the measurement year or the nine years prior

Community Health Plan's 2007 HEDIS colorectal cancer screening rate reflected 55.78 percent of the eligible population obtained this screening in 2006. These results aligned well with national performance (55.62 percent) and are above the Kansas City average (52.04 percent). This data indicates almost half of our members do not obtain this preventive screening. Please help your patients by educating them on the importance of this screening.

Source: *NCQA: The State of Health Care Quality 2007 Industry Trends and Analysis.*

Network News is published by Community Health Plan to provide network health care providers with current information regarding administrative changes, program updates and other health plan news.

To change your address or suggest an article for future Network News editions, please contact:

Client Services  
Community Health Plan  
137 N. Belt Hwy.  
St. Joseph, MO 64506  
(816) 271-1247 or (800) 990-9247



COMMUNITY  
HEALTH PLAN  
www.mychp.com

## Follow-up process after a behavioral health inpatient stay

Community Health Plan works with outpatient providers and inpatient facilities to ensure that our members have an appointment with an outpatient behavioral health provider within seven days following discharge from a behavioral health hospital stay. Behavioral Health care managers make follow-up calls after every inpatient mental health

hospitalization. The designated aftercare provider's office will be contacted to determine if our member was able to attend his or her appointment. Behavioral Health care managers also attempt to contact each member or his or her legal guardian before the first outpatient appointment to serve as a reminder for the upcoming outpatient services.

### MyCHP Service

Using MyCHP Service at [www.mychp.com](http://www.mychp.com) is quick and easy. Simply log in to MyCHP Service and research a variety of information from claims and enrollment status to prior authorizations and appeals.

# Appeals process

Members may request reconsideration of a plan decision through our appeals process (for example, an adverse authorization decision for a procedure or treatment that might be considered experimental, or a claim denial for non-participating provider services). If the member's life, health or ability to retain maximum function will be jeopardized by the appeals process standard time frame, CHP will expedite the appeal review process. For an expedited appeal, CHP reviews and makes a determination within 72 hours of receipt. Members may use a verbal or written request to initiate an expedited appeal. Members or their representative should call Community Health Plan at (816) 271-1037 or (800) 990-9247, ext. 1037 to request an expedited appeal.

To begin the standard appeals process, CHP should receive a written request from a member, a representative chosen by the member, or a provider who has financial recourse against a member. An appeal must be sent in writing to Community Health Plan within

180 days from the notification date of an adverse determination. Members or their representative have the opportunity to submit medical records, written comments, and documents related to their concern, when presenting an appeal to CHP. We acknowledged appeals by letter. A complete investigation is then pursued with involvement of qualified clinical personnel when required. We will send written notification of the appeal resolution and rights for a second level appeal (when available) once the investigation is complete.

Please remember, Community Health Plan has a process in place to answer and resolve questions for our providers. When your office has questions regarding claims processing or payment, you may reference *MyCHP Service* by visiting [www.mychp.com](http://www.mychp.com). Community Health Plan Customer Service is also available for any questions that are not resolved: (816) 271-1247 (option 2) or (800) 990-9247 (option 2).

# Continuity and coordination of care

Continuity and coordination of care are influenced by quality. Patients with complex needs require coordination between the different physicians caring for them and their case manager. CHP has developed a form to help facilitate the coordination of care. The form is located at [www.mychp.com](http://www.mychp.com) under Providers, just select Coordination of Care Form.

It is the PCP's responsibility to set up the initial referral appointment to the specialist's office and document the time and date. It is also the PCP's responsibility to communicate the following:

- Reasons for the referral
- Services requested from the specialist

- Current relevant information such as lab/test results, medication changes
- Physician notes
- What type of response the PCP is requesting from the specialist

It is the specialist's responsibility to communicate to the PCP what diagnostics and tests they would like to order, their findings and their recommendations. This form or a progress note should be completed and sent to the appropriate physicians and kept with the patient's medical record. If you have any questions, please contact the Care Management Department at (816) 271-4019.

## CLAIMS CORNER

Community Health Plan is proud to report the following claims statistics for the month of December 2007:

**Average turn around time (clean claims paid from received date)**  
6.63 calendar days

**Auto adjudication**  
79.59 percent

**Electronic claim submission**  
78.20 percent

**Claims finalized in 30 days**  
98.78 percent

## Individual pre-existing condition clause

Community Health Plan's Value and Value Plus individual products have a pre-existing condition clause. This means that anything a member has been treated or seen for in the last six months will not be covered for the next 12 months. An example is if a member broke his/her right leg, that broken right leg would not be covered for the next 12 months. However, Community Health Plan will cover a broken right ankle.

## HMO product, single tier: no out-of-network benefits

Community Health Plan members with the single tier HMO product do not have out-of-network benefits. CHP members being sent to a non-participating provider by their PCP is a continuing problem that can be avoided. The provider's reception staff should check the member's insurance card and verify the type of product and that it is current every time the member presents for services. If the PCP feels that the services needed are not accessible within our provider network, a prior-authorization can be requested for out-of-network services by calling (816) 271-1247 or (800) 990-9247. Choose option 3 for providers then option 2 for medical prior-authorization.

## CUSTOMER SERVICE

Community Health Plan is proud to report the following customer service statistics for the month of December 2007:

**Abandonment rate (percentage of lost calls)**

5 percent

**Average speed of answer**

28 seconds

## Quality of care reviews: patient safety tool

Community Health Plan's Quality Improvement (QI) Department investigates specific cases identified as possible quality of care concerns. Examples of quality of care concerns we review are unplanned readmissions within seven days and quality of care issues reported by members. QI investigated 62 quality indicator-related cases as potential quality of care issues during fiscal year 2007. The medical director reviews and assigns a level of severity to the quality of care cases (Level 0 {no concern substantiated} to Level III {concern is of a serious nature}). The medical director will decide if we need a corrective action plan from the provider involved or will forward the concern to the Provider Relations/Quality Review Committee for external peer review. QI determined that one of the cases reviewed in 2007 was a quality of care concern of a minor nature such as the lack of documentation of a treatment plan. Five of the cases in 2007 we found to be of a moderately serious nature such as a preventable surgical complication. There were no Level III cases found in 2007. We will include cases with actual quality of care concerns in provider files for consideration in the recredentialing process.

### Provider Satisfaction Survey

Be sure to complete the Provider Satisfaction Survey that was recently distributed. This information is very valuable to CHP and helps us provide excellent service to you.

## Medical record review

Community Health Plan (CHP) routinely reviews primary care provider medical records to evaluate the quality of care for our members. CHP will conduct reviews that evaluate several components, including documentation practices, quality and continuity of care, and determine that record documentation is current, detailed, organized, and permits effective patient care and quality review. Our medical record review will take place between March and May for select offices.

CHP provides the results of the review in writing to the practitioner. The report will include the performance standard established and the practice office site performance. If established goals are not achieved, a letter with suggestions will be sent. Corrective action plans and/or educational sessions may be required when performance on certain critical criteria falls below goal.

## New technologies

When we receive requests for new technologies we check the safety and efficacy of the product or procedure. To ensure quality to our Community Health Plan members, we research these requests through the use of a national evidence-based resource company, Milliman Care Guidelines.

Milliman Care Guidelines Company reviews thousands of current studies. The guidelines are designed to be used with health-care professionals' clinical judgment and provide up-to-date, evidence-based knowledge, enabling more informed, consistent decisions. These guidelines are updated annually and include Ambulatory Care, Inpatient and Surgical Care, General Recovery Guidelines, and Chronic Care Guidelines.

Periodically we have requests for technologies that have not been

reviewed by the above research company. These requests require further research through the manufacturer website or [www.clinicaltrials.gov](http://www.clinicaltrials.gov). We also accept research articles from the requesting provider's office.

- Critical criteria are identified as having a high potential for quality issues and 90% compliance is required. The following are considered critical criteria:
- There is a current problem list/history
  - There is a current medication list/history
  - Allergies/adverse reactions are displayed prominently
  - Appropriate past medical history is in the record
  - A pertinent history and physical exam is taken (recommend "SOAP" format)
  - PCP has reviewed summaries, lab, and other test results

The Community Health Plan Medical Records Documentation Standards are listed in the Quality Improvement Section (Section VI) of the Provider Reference Manual, which is online at [www.mychp.com](http://www.mychp.com).

Please allow additional time for the requests for new technologies since the review process cannot be safely handled in 48 hours. We always consider the needs and safety of our member's first along with the above review of information. This composite of information is presented to our medical director for review. The medical director's decision will be made based on our research findings and the member's clinical information received from the requesting provider.

# Benefit summaries

Please note the following list of renewed, new and termed groups with Community Health Plan:

Renewed Groups	Product Type	Effective Date
Auto Tool & Paint, Inc.	GPM2200, GPK2200	12/1/2007
Bottorff Construction Company, Inc.	GPM0935, GPK0935	12/1/2007
Cotter Travel Associates, Inc.	GPM0540, GPK0540	12/1/2007
Delmark Tire Service, Inc.	GPM2250, GPK2250	12/1/2007
Eggen's True Value Hardware	PPM3380	12/1/2007
Goldberg, Sullivan & McCrerey, Inc.	PPM1700	12/1/2007
R & M Pole Line Construction, LLC	GPM2900, GPK2900	12/1/2007
R & W Tow & Recovery, Inc.	GPM2260, GPK2260	12/1/2007
System Builders, Inc.	GPM3350, GPK3350	12/1/2007
Tedd Cycle, Inc.	PPM2840	12/1/2007
United Pharmacal Company, Inc. d/b/a UPCO	GPM1255, GPK1255	
	PPM1255	12/1/2007
Whetstine Farms	GPK0520	12/1/2007

New Groups	Product Type	Effective Date
Ally Enterprises	PPM3900	12/1/2007
Northwest Fertilizer, Inc.	GPM3880, GPK3880	12/1/2007
Pine View Manor, Inc.	GPM3870, GPK3870	12/1/2007

Termed Groups	Product Type	Effective Date
Reynolds Collision & Alignment, Inc.	PPM2880	11/30/2007
Test & Measurement	PPM3400	11/30/2007

**Community Health Plan**

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