providerNEWS

A Newsletter for **Freedom Health** & **Optimum HealthCare** Providers

SUMMER **2021**

Authorization Review & Determination

PARTNER WITH CASE and Disease Management Nurses

REQUESTS FOR Additional Information on Organizational Determinations

AND **much more!**

Printed and mailed 06/14/2021

A Patient-Centered Approach

As a health plan that is always striving to improve our strategies in order to affect the health outcomes of your patients, we would like to share with you an approach that has been proven to work. The Patient-Centered Medical Home model (PCMH) and other similar models have been recognized for their various benefits to the patient, providers, health plans and the overall health care system. Two major advantages are maximizing health outcomes and cutting down unnecessary cost by putting the patient first.

Freedom Health/Optimum HealthCare supports and ascribes to a Medical Home Model. With the ongoing research and support from accrediting agencies, many practitioners have pursued the Accountable Care Organization (ACO) or PCMH accreditation to focus on positive patient outcomes. Florida providers, in particular, have taken increased initiative in implementing these models and thereby earning recognition for their commitment to their patients. You can review the list of over 1,000 practices in Florida on the National Committee for Quality Assurance (NCQA) site **(https://reportcards.ncqa.org)** who are dedicated to improving their patients' health.

For more information on why these accrediting programs are so widely adopted in the Country, please visit **http://www.ncqa.org/Programs/Recognition.aspx**

ADVANCE DIRECTIVES

A Patient's Right to Decide

According to state and federal laws, patients have the right to decide how they are medically treated, even if they are not able to speak or make their wishes known. The Plan does not condition treatment based on whether or not a patient has executed an advance directive. We expect our contracted providers to uphold this standard of non-discrimination as well.

In order to prepare for these situations in advance, we encourage our members to express their wishes by filing advance directives. It is a patient's individual choice whether or not to file an advance directive. Common types of advance directives include Living Wills, Health Care Surrogates and Anatomical Donations.

Remember, a patient's medical record must contain documentation of whether or not the individual has executed an advance directive; documentation is to be displayed in a prominent location in the record. The Plan and its providers are not required to provide care that conflicts with a member's advance directives.

If your patients are interested in learning more about advance directives, you can refer them to the following resources:

Donate Life Florida
Website: http://www.donatelifeflorida.org
This site offers information on organ and tissue donation as well as the option to register as a donor online.

Florida Agency for Health Care Administration
Website: http://ahca.myflorida.com
This official website has a Health Care Advance Directives Publication called The Patient's Right to Decide. This publication provides helpful information on Advance Directives, forms, and other resources.

Florida Department of Elder Affairs
Website: http://elderaffairs.state.fl.us/index.php
Phone: 1-800-963-5337
Their website offers many resources for seniors including the Senior Legal Helpline: **1-888-895-7873**, a free legal consultation for seniors.

The Florida Bar Association
Website: http://www.floridabar.org
The Florida Bar provides information for the public on certain general areas of law. This includes Advance Directives, Living Wills, and Health Care Surrogates. They provide helpful brochures, forms, and other useful information for healthcare planning.

Aging with Dignity
Website: http://www.agingwithdignity.org
Phone: (850) 681-2010
This organization has a document called Five Wishes. This document allows you to express how you want to be treated if you are seriously ill and unable to speak for yourself. This document meets the legal requirements of an Advance Directive in most states.

Caring Connections
Website: http://www.caringinfo.org
Phone: (800) 658-8898
Caring Connections is a program of the National Hospice and Palliative Care Organization (NHPCO). This organization works to improve care at the end of life. Their website provides many resources for planning ahead. You can also download your state-specific Advance Directives.

Antidepressant Medication Management for PCPs

Many people with depression are seen and treated in the primary care setting. Therefore, it is important for primary care physicians (PCPs) to screen patients for depressive symptoms.

In addition to hallmark symptoms, many people with depression have vague somatic complaints, for which there's no disease explanation. Left untreated, comorbid depression can lead to poorer outcomes and prognosis of other diseases as well.

For more information about various behavioral health topics, consult Beacon Health Options' PCP toolkit by visiting https://providertoolkit.beaconhealthoptions.com/.

Choosing the right medication

Deciding which antidepressant medication to use can be challenging. Three important factors help determine medication efficacy:

1. COMPLIANCE. About 42 percent of patients discontinue their antidepressants during the first 30 days.

2. DURATION OF TREATMENT. An antidepressant can take 4-6 weeks to have a full effect, and a treatment episode should be at least six months after remission of symptoms or longer, depending on patient history.

3. ADEQUATE DOSING. Many antidepressants will need dosage adjustments to see full therapeutic effect. If seeing partial response, try increasing the dose before switching.

COMMON SYMPTOMS OF DEPRESSION

- Two weeks of persistently depressed mood
- Inability to feel pleasure
- Sleep difficulties
- Appetite and energy level changes
- Lost interest in activities
- Guilt and suicidal thoughts

Presenting symptoms, comorbid conditions, and possible drug interactions should drive treatment decisions. If a person has had a prior good response to a medication, that medication should be initiated first. There are several classes of antidepressant medications: SSRIs, SNRIs, Tricyclics, MAOIs and atypical antidepressants. SSRIs and SNRIs, the most commonly prescribed antidepressants, have varying side effects, but nausea and headache are most common. To mitigate these transient side effects, start your patient at a low dose and titrate up as side effects subside.

Always see patients within a few weeks of initiating a medication to assess side effects, medication adherence and to screen for thoughts of self-harm. If a patient has thoughts of self-harm, refer that patient for immediate assessment. Beacon can help with referrals to both inpatient and outpatient providers by calling **(888) 273-3710.**

AUTHORIZATION REVIEW & DETERMINATION

IN THIS ISSUE, we would like to address one of the biggest requests we received from our providers on our provider survey – tell me more about Medicare guidelines that influence an authorization review and determination.

The Utilization Management (UM) department, including clinical staff, is available for all pre- certification requests and questions, Monday through Friday from 8:00 a.m. to 5:00 p.m. Our staff is also on call after hours and on weekends to handle discharge planning requests from facilities and other emergent needs.

The UM Department uses the following criteria when making a determination for our Medicare members:

- Medicare National and Local Coverage Guidelines
- State Statutes, Laws and Regulations
- InterQual Criteria
- Hayes Medical Technology
- Policy/Benefit Coverage
- Medical Director professional judgment based on review of literature, evidence-based guidelines, & other Managed Care Organizations

FOR DUAL MEDICARE/ MEDICAID MEMBERS the UM Department also uses the Agency for Healthcare Administration (AHCA) and Medicaid Coverage and Limitation Guidelines.

In addition to using its own Medical Directors, the UM Department uses board-certified consultants as appropriate to assist in making medical necessity determinations.

TIMEFRAMES:

For standard requests, the Health Plan processes authorization requests as quickly as possible. Many of our requests are completed on the same day received, and our average turnaround time for all requests for service is less than 2 days. We urge our providers to include all necessary medical records when submitting a request in order to avoid unnecessary delays.

STANDARD REQUESTS MAY BE SUBMITTED BY FAX: 866-608-9860 OR 888-202-1940

For expedited requests, the review must be completed, including a notification to the member, within 72 hours from the time received at the Health Plan. Please note that a request should only be submitted as expedited if it is felt that waiting up to the standard time for a decision would place the patient's life, health or ability to regain maximum function in serious jeopardy.

EXPEDITED REQUESTS MAY BE SUBMITTED BY PHONE: 888-796-0947 OR BY FAX: 866-608-9860 OR 888-202-1940

HOW TO CHECK THE STATUS OF A REQUEST

- Call the UM Department during normal business hours, 8:00 a.m. to 5:00 p.m. on weekdays, to check the status of a request; or
- Access the Health Plan's Provider Portal, where you can review the status of a member's authorization request. If you have questions regarding the Provider Portal or would like access, please contact your Provider Relations representative for assistance.

CREDENTIALING CORNER

The Plan Accepts CAQH Proview Credentialing applications.

Please continue to keep your credentialing application information and attached documentation current in the CAQH Proview data base. When logging into your ProView Provider Sign-in, please take note of the informational banners that CAQH uses to announce updates to their system, as well as the monthly emailed CAQH ProView Updates. Also, please ensure the following items are updated and current:

- State Medical License(s) please include expiration date(s)
- DEA Certificate
- Valid Insurance Information
- Practice locations
- Hospital Admitting privileges OR if you are a PCP and you do not have hospital admitting privileges please ensure the Hospital Admitting Arrangements Supplemental Form is fully completed
- Partners/Covering Colleagues
- Questionnaire responses and explanations as required.

For Providers Not Part of the CAQH Proview:

The plan sends notification and re-credentialing applications by mail four months in advance of a providers credentialing expiration date. The notification cover letter specifies the steps and documents needed for re-credentialing, as well as the deadline for the submission of all current information.

Active provider status is dependent upon completion of the re-credentialing process prior to the three- year expiration date.

Thank you for your timely submission!

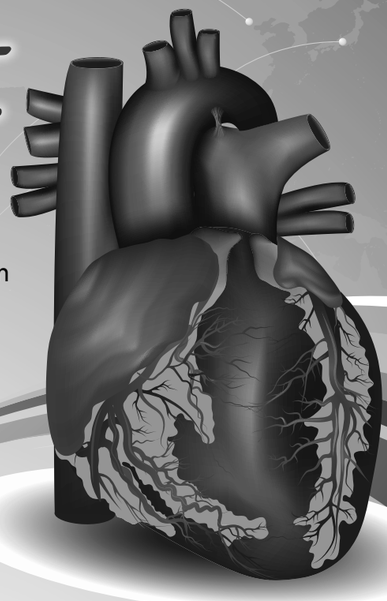
……and just a quick reminder, please promptly notify us of any change in your location or other credential, or if you are adding a new practitioner to your practice.

Diabetes and SELF-ASSESSMENT

With a growing population and expansion of coverage via the Affordable Care Act, more and more people have access to medical care. While this is beneficial, it does not automatically improve patient health and outcomes. As a physician you have the knowledge and ability to diagnose and treat patient medical conditions.

When patients come to see you, they rely on your assessment to identify problems which they may have overlooked. Encouraging patients to perform foot self-examinations on a regular basis can help them recognize potential medical issues, which is especially important for diabetic patients. Training them to assess themselves for skin integrity, perfusion, wounds, and sensation can lead to early detection of complications and early interventions. This may result in lower healthcare costs; it also encourages patients to take responsibility for their health, making them true partners in their own healthcare.

DON'T FORGET THE STATINS!



American College of Cardiology and American Heart Association (ACC/AHA) guidelines recommend moderate or high-intensity statins for adults with clinical atherosclerotic cardiovascular disease (ASCVD). Likewise, there are related quality measures that promote statin use in the CMS Medicare 2021 Part C & D Star Ratings.

The NCQA HEDIS® measure, "Statin Therapy for Patients with Cardiovascular Disease (SPC)," aims to encourage providers to prescribe the most effective drugs to treat high cholesterol in members with heart disease.

Specifically, this measure calculates the percentage of males 21-75 years of age and females 40-75 years of age in your patient population with clinical ASCVD, who were dispensed at least one high or moderate-intensity statin medication during the measurement year. The goal is to reduce major cardiovascular events in members who have been diagnosed with ASCVD.

The measure excludes members who:

- Were diagnosed with ESRD during the measurement year or the year prior.
- Were diagnosed with cirrhosis during the measurement year or the year prior.
- Were diagnosed with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.
- Had palliative care during the measurement year.

Other exclusions which may not apply to many Medicare Advantage-age members are:

- Pregnancy or in vitro fertilization during the measurement year or the year prior.
- Members who were dispensed at least one prescription for clomiphene (Estrogen Agonist Medication) during the measurement year or the year prior.

Diabetics are another group at a higher risk for developing heart disease. The "Statin Use in Persons with Diabetes (SUPD)", which is adapted from the measure concept developed by the Pharmacy Quality Alliance (PQA), indicates most diabetics should take cholesterol medication to lower high cholesterol. Members between 40-75 years old who received at least two diabetes medication fills and received a statin medication fill during the measurement period are included in this measure.

The measure excludes members who, during the measurement period:

- Were enrolled in hospice.
- Were diagnosed with ESRD or had dialysis coverage.
- Were diagnosed with rhabdomyolysis or myopathy.
- Were diagnosed with liver disease.
- Were diagnosed with pre-diabetes.

Other exclusions which may not apply to many Medicare Advantage-age members are those who:

- Were diagnosed with polycystic ovary syndrome (PCOS).
- Were pregnant, lactating or undergoing fertility treatments.

These generic statins have a $0 co-pay and are covered through the gap or "donut hole". They are also covered up to a 100-day supply:

- Atorvastatin
- Rosuvastatin
- Simvastatin
- Lovastatin
- Pravastatin

You prescribe the most effective medications because you care about your patients and want to help them avoid cardiovascular events and stay as healthy as possible. Proactive prescribing can also raise your HEDIS® scores and Star ratings. Do the best for your patients and your practice – don't forget the statins!

Partner with Case and Disease Management Nurses

The Plan can collaborate with you to help provide members the services they need to better manage their health or plan of care. You can refer a patient to Case Management, Disease Case Management or Social Work with just a phone call or written referral. Our goal is to support the member's success in implementing his or her plan of care. The referral form can be found on the Plan's website or in your Provider Manual.

Disease Case Managers offer education and coaching programs for members based on chronic conditions such as Diabetes and Cardiovascular Disease. These programs are built around national evidence-based guidelines. The focus is on preventing complications and/or exacerbations, enhancing self-management and reducing acute episodes.

Complex Case Managers can assist members with urgent or acute events and coordination of services. The goal is to enhance coping and problem-solving capabilities, assist in appropriate self-direction, support proper and timely services, and reduce readmissions.

Social services support is integrated into our Case and Disease Management program. Our Social Workers work in conjunction with our Nurses to identify health and community resources which might benefit the member.

Members enrolled into one of our Case and Disease Management programs, and their physicians, receive ongoing support from nurses on staff. Members may choose not to participate in the program at any time and it does not affect their benefits.

Many times, nurses or social workers will need to engage the PCP to resolve members' concerns or issues. We appreciate when providers support member participation in these programs as a collaborative effort to maximize health and wellbeing. Provider communication efforts are also enhanced via a care plan developed by the nurse and/or managed care coordinator along with the member, highlighting mutually agreed-upon goals and interventions. Updates to the care plan are provided as well when initiatives change.

Call us toll-free at 1-888-211-9913 from 8:00 a.m. to 4:00 p.m. Monday through Friday. To access the referral form on the internet visit the Plan website and follow this path: Providers -> Tools and Resources -> Case/ Disease Management Referral Form

Evidence-based Clinical Practice Guidelines

The Plan reviews and adopts Evidence-based Clinical Practice guidelines in consultation with the Plan's Manager Medical Director and/or Medical Director(s), a panel of physicians, an interdisciplinary care team of board-certified specialists and the Quality Management Steering Committee.

The Plan utilizes evidence-based clinical practice guidelines on which it bases its management of members' health care needs, including the development of all disease-based assessments, education of members on suggested self-care, condition monitoring and care plans.

The Plan updates its practice guidelines periodically and reviews them at least annually. National agencies and medical specialty societies also adopt evidence-based clinical practice guidelines. They are based on reasonable medical evidence or the consensus of physicians in a particular field.

Adapted to the needs of the Plan's members, the guidelines are included in the Care Plan Manual sent to primary care providers. They are available to members when appropriate and upon request. A copy of the evidence-based clinical practice guidelines and the links to their sources are available on the Plan's websites at:

www.freedomhealth.com -> Providers -> Tools & Resources - > Clinical Healthcare - > Clinical Practice Guidelines

www.youroptimumhealthcare.com -> Providers -> Tools & Resources - > Clinical Healthcare - > Clinical Practice Guidelines

REQUEST FOR ADDITIONAL INFORMATION
on Organizational Determinations

When the Utilization Management (UM) Department receives a PCP's organizational determination request, complete clinical information from the member's health record is necessary to determine whether clinical guidelines for specific requested services are met.

UM uses phone and fax communication to reach out to providers. UM has a process and policy in place that mirrors CMS guidance, emphasizing that outreach be made as early in the coverage decision process as possible.

In order to assure rapid authorization turnaround times, the PCP should respond on the same day to information requests from UM. This is especially critical if the request is expedited. Quick response times from PCP's contribute significantly to our goal of completing all standard organizational determinations within 5 days.

This same process of PCP outreach occurs when requests for services are received from a provider other than a member's PCP. In these cases, UM will notify the member's PCP about the request, including the clinical information received with the request, and seek PCP review and input on the request.

If a PCP does not respond to an information request in a timely manner, the request and information will be forwarded to the health plan's Medical Director for a final decision. Having all relevant information available leads to more informed, accurate decisions, so timeliness of PCP response is important. A PCP's quick response to UM requests assure the Plan has relevant PCP medical records and clinical opinions for UM decision-making.

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FREEDOM HEALTH

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provider NEWS

SUMMER 2021

IN THIS ISSUE

Language Access on the Plan *Website*

In order to make sound health care decisions, members must be able to understand their health insurance benefits as well as how to navigate the health care system. Our Spanish-speaking members account for the Plan's highest preferred language other than English. With that in mind, we have identified opportunities to help ensure that our members are equipped with the necessary tools.

We are proud that Freedom Health and Optimum HealthCare are striving to have a more bilingual website presence. Our Plan website at www.freedomhealth.com and www.youroptimumhealthcare.com is Spanish language enabled, making it easier to navigate to the information the members need. We are continuing to identify opportunities to make health plan information more accessible to all our members and look forward to sharing more about our achievements with our valued providers.