The Inside Story

Scott & White Health Plan
Now part of Baylor Scott & White Health

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The second half of 2015 is proving to be just as busy as the first half was for Scott & White Health Plan (SWHP). Our new Provider Interactive Voice Response (IVR) System went live on 08/14/2015. The Provider IVR was implemented to offer a faster way for you to obtain information about member enrollment status, member benefits, and claims status.

We also worked diligently to prepare for the conversion from ICD-9 to ICD-10 that occurred on 10/01/2015. SWHP teamed with several providers, clearinghouses, and vendors to conduct testing. In addition, we conducted two ICD-10 Training Seminars and created an ICD-10 Frequently Asked Questions and ICD-10 Training PowerPoint that are currently available on the SWHP website.

SWHP is currently working on a new website design that is scheduled to launch in November 2015. We are very excited to offer an enhanced and user-friendly digital experience to our members and providers!

As we approach the new year, SWHP is implementing various tools, processes, and policies and procedures to ensure we are in compliance with all of the upcoming regulatory requirements that go into effect throughout 2016, including Affordable Care Act Administrative Simplification, provider enrollment requirements for writing prescriptions for Medicare Part D drugs, provider directory accuracy requirements, and etc.

We look forward to our ongoing partnerships with all of our providers as we collaborate to continue to provide high-quality and cost-effective care to our SWHP members.

In This Issue

PROVIDER INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

Scott & White Health Plan (SWHP) is excited to announce that our new Provider IVR went live on 08/14/2015. The Provider IVR was implemented to offer a faster way for you to obtain information about member enrollment status, member benefits, and claims status. By utilizing the Provider IVR, you no longer have to wait on the phone to speak with a Customer Service Advocate (CSA). **Please note that the information received from the Provider IVR is generated from the same system that the CSAs use. Therefore, there is no need to wait to speak with a CSA on the phone to validate the information received from the Provider IVR.** We realize that you are busy delivering healthcare services to our members, so we want to offer you tools to obtain the information you need efficiently.

You can access the Provider IVR directly by dialing 1-800-655-7947 or by calling the SWHP Customer Advocacy Department phone number at 1-800-321-7947 and selecting option 1. The Provider IVR is available 24 hours a day, 7 days a week. If the system is unavailable or is having technical difficulties, then you will be routed to a CSA for assistance.

SWHP values the relationships that we have with our providers, and we are committed to providing you with the highest level of service.

ICD-10 HELPFUL DOCUMENTS

Scott & White Health Plan (SWHP) values the relationships that we have with all of our participating providers that deliver high-quality and cost effective healthcare to our SWHP members. We look forward to continuing our partnership with you as we work collaboratively to meet the various federal and state requirements that are being mandated. As such, we have created some helpful documents to answer many of your questions and provide you with valuable information regarding the recent transition to ICD-10 on October 1, 2015. We want to provide as much assistance as we can to our provider partners to ensure everyone has a successful conversion, with our top priority being to avoid disruption in services to our SWHP members. **To access the ICD-10 PowerPoint Training and ICD-10 Frequently Asked Questions (FAQs) documents that we have available, please visit the SWHP website at https://swhp.org/providers/training-education.**

If you have any questions or need assistance locating the ICD-10 materials on our website, please do not hesitate to contact the SWHP Provider Relations Department at 1-800-321-7947, ext. 203064 or 254-298-3064.

PRESCRIBER ENROLLMENT REQUIREMENTS FOR MEDICARE PART D DRUGS

The Centers for Medicare and Medicaid Services (CMS) finalized rule CMS-4159-F on May 23, 2014, which requires physicians and other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be covered under Medicare Part D. CMS originally planned to enforce this requirement beginning December 1, 2015. However, CMS made revisions to rule CMS-4159-F on May 6, 2015. The revised rule is published as CMS-6107-IFC, which went into effect on June 1, 2015.

Under the revised rule CMS-6107-IFC, CMS is delaying enforcement of the prescriber enrollment requirements until June 1, 2016. The revised rule also encourages Part D sponsors and pharmacy benefit managers (PBMs) to begin outreach activities to Medicare Part D prescribers no later than January 1, 2016. Therefore, prescribers may be contacted multiple times from the various Part D sponsors and PBMs with whom they participate.

CMS strongly encourages prescribers of Part D drugs to submit their Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) before January 1, 2016. This will provide the MACs with sufficient time to process the prescribers' applications or opt-out affidavits and avoid prescription drug claims from being denied by the Part D plans, beginning June 1, 2016.

For more information, please visit the CMS Part D Prescriber Enrollment website at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Prescriber-Enrollment-Information.html.

Balance Billing Scott & White Health Plan Members

Balance Billing the Patient

Scott & White Health Plan (SWHP) does not allow contracted providers to balance bill patients for covered services.

Balance billing is the practice of billing the patient for the difference between what SWHP pays for covered services and the "retail" price you charge uninsured patients for those services.

Review Your Participating Provider Agreement for Details

In your participating provider agreement (contract) with SWHP, it states that you shall not look to SWHP members for payment for covered services, except to the extent that the applicable Plan specifies a copayment, coinsurance, or deductible or the service is not a covered benefit.

Balance Billing Rules under Medicare

The Center for Medicare and Medicaid Services' (CMS) Medicare Managed Care Manual, Chapter 4, Section 170, states in part, "Medicare Advantage members are responsible for paying only the plan-allowed cost-sharing (copayments or coinsurance) for covered services."

If a member inadvertently pays a bill, which is SWHP's responsibility, you must refund the amount to the enrollee.

For additional information or questions, please contact the SWHP Provider Relations Department toll-free at 1-800-321-7947, ext. 203064 or locally at 254-298-3064.

Chronic Obstructive Pulmonary Disease

According to the Centers for Disease Control and Prevention (2015), 6.8 million adults were diagnosed with Chronic Obstructive Pulmonary Disease (COPD) during the past year, equaling 2.9% of the adult population. With COPD being statistically prevalent, it is imperative that patients receive appropriate testing to confirm the diagnosis of COPD.

Spirometry plays a vital role in determining the severity of COPD, but can also play a role in determining the severity of other conditions like asthma. Spirometry can determine exactly how severe each respective condition is and can help determine the ultimate course of treatment.

Scott & White Health Plan (SWHP) monitors a Healthcare Effectiveness Data and Information Set (HEDIS) measure dedicated to the Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR). SPR is broken down by determining if a member received appropriate testing to confirm the diagnosis of COPD within six months of the diagnosis date (HEDIS 2015).

When diagnosing someone with COPD, please remember to order the appropriate testing to confirm the diagnosis and to determine the severity of the respiratory condition.

References

Centers for Disease Control and Prevention. (2015). Chronic Obstructive Pulmonary Disease (COPD): Chronic Bronchitis and Emphysema. Retrieved from http://www.cdc.gov/nchs/fastats/copd.htm.

HEDIS 2015 Technical Specifications for Health Plan (Volume 2). (2014). Washington, D.C. National Committee for Quality Assurance.

Best Practices for ADHD Care in Children

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) are common diagnoses in children (www.nimh.nih.gov). Parents often bring their children to a doctor for an evaluation when focusing at school and at home become an issue. Hyperactivity is present in some but not every child with ADHD. Teachers are frequently the first to notice focus problems in school age children. "Symptoms of ADHD may include: staying focused and paying attention, difficulty controlling behaviors and hyperactivity" (www.nimh.nih.gov).

Various medications can be used to treat ADHD in children based on the individual child's symptoms. These include CNS Stimulants, Alpha-2 Receptor agonists, and other ADHD medications. These medications can have various side effects that need to be monitored to achieve the treatment response needed.

Scott & White Health Plan (SWHP) works with Baylor Scott & White Health (BSWH) physicians and the National Committee for Quality Assurance (NCQA) to monitor the treatment and the prescribing of medications for school age children with ADHD, ages 6 to 12 years of age. Prescription compliance is monitored per prescription refills by the SWHP Claims Department.

SWHP is in compliance if the patient takes ADHD medication for 10 months with only a maximum 45 day gap between days 31 and 300. The measure allows 10 months of medication per year since many parents take their children off the ADHD medication on the weekend and during the summer months.

Follow-up care is essential in treating children with ADHD. In the Initiation Phase, children are prescribed an ADHD medication. Then in the Continuation and Maintenance (C&M) Phase, patients are required to have at least three follow-up visits per year (HEDIS Manual 2015).

While ADHD is often thought of as a childhood disorder, it can last into adulthood. ADHD in children is commonly associated with other mental health conditions in adulthood, so it is very important for the child to get the proper diagnosis and treatment at the earliest age possible (www.cdc.gov/ncbddd/adhd).

References

NIH. (n.d.). NIMH - *Attention Deficit Hyperactivity Disorder (ADHD)*. Retrieved June 25, 2015, from http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml

NCQA. (2014). Behavioral Health. *HEDIS 2015 Technical Specifications for Health Plans* (2015 ed., pp. 172-176). Washington, DC: National Committee for Quality Assurance.

www.cdc.gov/ncbddd/adhd

Asthma Medications

According to the Centers for Disease Control and Prevention (2008), over 1.2 million adults and over 590,000 children in Texas were diagnosed with asthma in 2008. Asthma is statistically prevalent in Texas, and it is imperative that members diagnosed with asthma have the appropriate medications to help manage and control various stages of asthma or asthma-related conditions.

First, there are rescue medications, which are specifically designed to provide immediate relief for asthma symptoms as they occur. It is important to make sure that rescue medications are not overused. Second, there are controller medications, which are specifically designed to work over a period of time to help alleviate inflammation in the airways over the course of time.

According to the Mayo Clinic (2012), if an individual does not use their controller medications as prescribed by their primary care physician, that individual's asthma can potentially become uncontrolled and increase their risk of a major asthma attack.

The Scott & White Health Plan (SWHP) monitors a Healthcare Effectiveness Data and Information Set (HEDIS) measure dedicated to Medication Management for People with Asthma (MMA). MMA is broken down to individuals that were on an asthma controller medication for at least 50% and at least 75% of the treatment period (HEDIS 2015).

Individuals diagnosed with persistent asthma are included in the MMA measure. Persistent asthma is defined as: one ED visit with the main diagnosis of asthma, one inpatient encounter with the main diagnosis of asthma, four outpatient visits with different dates of service, and two asthma medication dispensing events or four asthma medication dispensing events.
Please remember that any member that is diagnosed with persistent asthma should be prescribed an asthma controller medication.

References

Asthma in Texas. (2008). Retrieved from http://www.cdc.gov/asthma/stateprofiles/asthma_in_tx.pdf

HEDIS 2015 Technical Specifications for Health Plan (Volume 2). (2014). Washington, D.C. National Committee for Quality Assurance.

Mayo Clinic Staff. (September 8, 2012). Asthma medications: Know your options. Retrieved from http://www.mayoclinic.org/diseases-conditions/asthma/in-depth/asthma-medications/art-20045557?pg=1

Adolescent Well-Care Visits

Adolescence is one of the most dynamic stages of human development. Adolescence is a time when teens experience dramatic physical, cognitive, social, and emotional changes. It is at this time when many physical and mental health conditions, substance use disorders, and health risk behaviors first begin to appear. In fact, three out of four adolescents, ages 12–19, report engaging in at least one type of risky behavior, such as the use and abuse of alcohol and other substances, unprotected sex, poor eating and exercise habits, and physically-endangering behaviors (DHHS, 2014).

Healthy People 2020 noted that "the leading causes of illness and death among adolescents and young adults are largely preventable" (Hensley-Quinn & Osius, 2008). In fact, $700 billion is spent annually on costs directly and indirectly associated with preventable adolescent health problems (Hensley-Quinn & Osius, 2008). According to Healthy People 2020, "behavioral patterns during these developmental periods help determine young people's current health status and their risk of developing chronic diseases in adulthood" (Hensley-Quinn & Osius, 2008). The Centers for Disease Control and Prevention (CDC) estimates that 16% of high school students have seriously considered suicide with 13% reporting that they had actually created a plan to do so (CDC, 2015a). Also, the CDC states that almost 9 out of 10 cigarette smokers tried their first cigarette by the age of 18 (CDC, 2015b).

A comprehensive well-care visit for adolescents, ages 12 to 21, can provide the screening, health counseling, and treatment necessary to address five key areas of adolescent health:

1. Mental and behavioral health
2. Tobacco and substance use
3. Violence and injury prevention
4. Sexual behavior
5. Nutritional health

It is extremely important that adolescents receive annual well-care visits for early identification and appropriate management and intervention for conditions and behaviors that, if not addressed, can become serious and persist into adulthood.

What Counts as a Well Care Visit?

A well-care visit occurs with a PCP or OB/GYN in a clinical setting during the calendar year. The following documentation must be noted in the member's medical record:

1. Health history
2. Physical and mental development history
3. Physical exam
4. Health education/anticipatory guidance

A sick visit and a well-care visit can be billed at the same time, but all the components listed above must be included in the member's medical record. Sports physicals are also a great time to complete a well-care visit as long as all the components of the well-care visit are noted in the medical record.

References

CDC. (2015a, March). Suicide Prevention: Youth Suicide. *Centers for Disease Control and Prevention.*

CDC. (2015b, July). Youth and Tobacco Use. *Centers for Disease Control and Prevention.*

DHHS. (2014, February). Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits, *Department of Health & Human Services.*

Hensley-Quinn, M. and Osius, E. (2008, May). SCHIP and Adolescents: An Overview and Opportunities for States. *State Health Policy.*

Colorectal Cancer Screening Best Practices

Although the incidence of colorectal cancer (CRC) in the U.S. has been declining by 2% to 3% per year over the past 15 years, it continues to be the second leading cause of cancer-related deaths (Randel, 2012). Because 90% of all cases of CRC occur in people over 50 years of age, the American College of Gastroenterology (ACG) continues to recommend the use of a colonoscopy as the preferred standard for screening every 10 years beginning at age 50 (Rex, 2009). However, the ACG also recognizes that many patients are not willing to undergo a colonoscopy for a variety of reasons. As such, the ACG guidelines state that in these cases, an alternate method of testing should be used to screen for CRC. This includes flexible sigmoidoscopy (Flex Sig), computed tomography (CT-scan), guaiac-based fecal occult blood tests (GFOBT), and immunochemical based fecal occult blood testing (FIT) until the member is over 75 years of age or has an estimated lifespan of less than 10 years. This leaves both our providers and our patients asking what test I should have, when, what are the risks, and what are the benefits. To aid in the discussion of a care plan, I offer the below table.

Test	Sensitivity / Specificity	Cost	Frequency	Barriers	Risks
Colonoscopy	High	High	10 years	Bowel Prep, Cost, Limited Availability	Postpolypectomomy bleeding, perforation, diverticulitis, severe abdominal pain, death
Flex Sig	Medium	High	5 years	Bowel Prep, Cost	Perforation/bleeding, false negatives
CT Scan	Medium	High	5 years	Bowel Prep, Cost	Low-dose radiation exposure, additional diagnostic testing and procedures may be need for lesions that might not be clinically significant
Guaiac-Based Occult Blood Testing	Variable	Low	Annual	2-3 samples from consecutive stools at home	False Negatives
FIT Testing	High	Low	Annual	1 sample from a stool sample collected at home	No major risks

Again, we as healthcare providers know the risks and benefits of each of these tests. However, our members are the ones who must be willing to complete the prep, spend their time to get the test done or submit a sample. By discussing all the options with our members, they can choose the method of CRC screening that works best for them. This will increase our compliance rates and allow Scott & White Health Plan to catch this killer early. While our members see this as patient-centered care, we will reap the benefits of significant cost savings in the long run.

References

Randel, A. (2012). ACP Releases Best Practice Advice on Colorectal Cancer Screening. *American Family Physician*, 86(12), 1153-1154.

Rex, D. K., Johnson, D. A., Anderson, J. C., Schoenfeld, P. S., Burke, C. A., & Inadomi, J. M. (2009). Colorectal Cancer Screening. *American Journal of Gastroenterology*, 104, 739-750.

Cardiovascular Best Practices

Numerous research studies have shown time and time again that when it comes to the best practices for protecting the heart, the answer is as simple as our ABCs:

- Aspirin (as appropriate)
- Blood Pressure Control
- Cholesterol Management
- Smoking Cessation

Still, "the social and environmental origins of CVD [cardiovascular disease] have long been recognized as mediated in large part by lifestyles and behaviors that are modifiable. Cardiovascular health in children predicts subsequent cardiometabolic health in adulthood, affirming the importance of maintaining healthy lifestyle behaviors from early in life" (Pearson et al, 2013, p. 1732). The question then becomes, "how do we best modify these behaviors?" Bandura's Social Learning Theory poses that we learn the lifestyle behaviors through modeling of socially acceptable behaviors. Fact is the National Institute of Health (NIH), Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), American College of Cardiology (ACC), American Academy of Family Physicians (AAFP), and the American Heart Association (AHA) are all looking in the same direction; improving individual health by improving cardiovascular health and education at the community level.

In September 2011, the Department of Health and Human Services (HHS) launched the Million Hearts Initiative with the goal of preventing 1 million heart attacks and strokes by 2017. One innovation they presented was that of *Heart360*. Members were encouraged to record home BP readings at least 3-4 times per week and share them with their pharmacist. Pharmacists were empowered to make adjustments to Rx dosages based on these readings. At the end of the 6-month pilot, 57% of the previously uncontrolled HTN patients were now controlled as compared to the control group using standard office-based care's 37%. A similar program, the American Pharmacists' Association Foundation's Asheville Project, also allowed for pharmacy-based medication therapy management (MTM) for patients with HTN or dyslipidemia. Again, pharmacists were involved in both member education and adjustments of medications. Over the course of 6 years, this program actually reduced costs for asthma, CVD, depression, and diabetes by over $1200 per member per year and yet 50% more members met goals.

Another study was launched to look at the effects of culturally competent care for African-Americans with HTN. This program entailed training the nurses. Again, patients were encouraged to take home BP readings and report them to the nursing staff. The nurses were also trained to answer patient questions regarding BP monitoring, medication adherence, and other areas of culturally competent care, as well as, to relay BP readings to the providers. At the end of the study, nurse health coaching with culturally competent education resulted in a 36% increase in HTN control rates as compared to the baseline of office-based visits.

Meanwhile, the CDC and CMS teamed up to improve community based understanding of the need to improve antihypertensive medication adherence through the Epi-Exchange. Simply put, they worked together to optimize member access to both public health and clinical resources. In the process they not only increased transparency about how to access resources and information, but confirmed that when evidence-based best practices were collaborated through data-sharing across disciplines, patient compliance rates increased dramatically.

One can easily find numerous other studies, but it is sufficient to say they all have one thing in common. They have all changed their focus from treatment based solely on office visits to patient-centered care based on individual lifestyles and community based resources. How can we make our best practices user friendly for the community? The answer remains the same, we use our ABCs: Aspirin, Home BP Monitoring, Cholesterol Management, and Smoking Cessation, but with a twist. We now focus on the member as a whole and not just what we see at one office visit. When the entire health care team collaborates to send a consistent message in an environment of patient-centered care, only then can we say we have achieved the CVD best practices.

References

CDC. (2015). *Million Hearts; Innovatiuons & Progress Notes*. Retrieved September 2, 2015 from http://millionhearts.hhs.gov/about_mh.html.

Pearson, T. A., Palaniappan, L. P., Artinian, N. T., Carnethon, M. R., Criqui, M. H., Daniels, S. R., Turner, M. B. (2013). American Heart Association Guide for Improving Cardiovascular Health at the Community Level, 2013 Update; A Scientific Statement for Public Health Practitioners, Healthcare Providers, and Health Policy Makers. *Circulation*, 127, 1730-1753. doi:10.1161/CIR.0b013e31828f8a94.

Scott & White Health Plan Medical Coverage Policies Update

Scott & White Health Plan (SWHP) is pleased to announce the release of the following Medical Coverage Policies. You can find these policies on our website at https://swhp.org/providers/policies.

Number	Title	Comment
R003	Occupational Therapy	
R007	Autologous Chondrocyte Implantation	
R010	Hearing Aids-Bone-Anchored	
R011	Botulinum Toxin Injection for Chemodenervation	
R014	Apolipoprotein E Genotype of Phenotype	
R015	Non-Invasive Nerve Conduction Testing	
R018	IMRT for Breast Cancer	
R101	Regional Sympathetic Blocks	
R112	Speech Therapy	
R129	Organ Transplantation	
R130	Vagus Nerve Stimulation	
R213	Coverage Determination Final	
Update 043	INR Home Testing	
Update 208	Private Duty Nursing	
R012	Compression Garments	
R074	Occipital Nerve Stimulation	
R082	Phonophoresis	
R099	Pulsed Dye Laser Treatment	
R110	Sleep Apnea	
R141	Infertility	
R201	Ventricular Assist Device	
R205	Deep and Double Balloon Enterscopy	
R214	Chiropractic Services	
R215	Medications Covered Under Medical Policy	
R037	Genetic Testing	
R044	Hyperbaric Oxygen Therapy	
R078	Spinal Cord Stimulators	
R084	Vertebroplasty Kyphosplasy Sacroplasty	
R028	Durable Medical Equipment	
R029	Alzheimers Disease Biochemical Markers	
R030	Osteoporosis Bone Turnover Markers	
R031	Epidural Adhesiolysis	
R035	Cold Therapy Devices	
R036	Gastric Electrical Stimulation	
R045	Immune Globulin Therapy	
R048	Incontinence Alarms	
R050	Cancer Vaccines	
R067	Neutralizing Antibody Testing in Multiple Sclerosis	
R064	Gender Reassignment	

The SWHP Medical Coverage Policies are reviewed on an annual basis to assure continued relevance and to keep them current. This review is conducted by SWHP Medical Directors. Each policy is reviewed using a number of resources, such as:

1. Medical literature
2. InterQual® guidelines
3. SW Technology Assessment Determinations
4. Specialty Society or other national guidelines

Once policies have been reviewed by the SWHP Medical Directors, they are sent for specialty review. Recommendations from the specialty reviewers are considered at a subsequent Medical Director Committee Meeting, and a final decision on the content of the policies under consideration is made.

The review process for the above policies has been completed, and they have now been published to the website. Your comments and suggestions regarding the Medical Coverage Policies are always welcome and may be forwarded to: SWHPMedicalDirectors@sw.org.

SWHP/ICSW Utilization Management Criteria for Inpatient Services and Selected Benefit Coverage Determinations 2015

The Scott & White Health Plan (SWHP)/Insurance Company of Scott & White (ICSW) Insurance Policy also referred to as Evidence of Coverage (EOC) or Standard Plan Document (SPD) is the contract for coverage of the health care services that an individual purchased or an employer purchased for their employees. SWHP/ICSW provides a variety of benefit plans to meet purchaser needs.

Benefit plans include benefits required by law to be offered by the SWHP/ICSW, as well as, purchaser preference (ASO). The purpose of SWHP's Utilization Management (UM) Program is to manage services according to the terms contained in the Insurance Policy. All benefit plans require coverage to be contingent upon medical necessity. SWHP's Utilization Management Committee adopts or develops evidence-based criteria to determine medical necessity. Annually, SWHP provides proposed criteria to physician directors of Baylor Scott & White Health's Medical Services Divisions and contracted network physicians for review and feedback. SWHP/ICSW Medical Directors evaluate all feedback provided. The resulting approved final criteria sets and the HealthCare Management Guidelines (target length of stay (LOS)) are forwarded to the SWHP/ICSW UM Committee for review and approval.

2015 criteria include InterQual®, internal policies, target LOS, criteria developed and approved during Technology Assessment meetings, and medical coverage policies.

The approved criteria are used by the UM Staff as a guideline only. SWHP/ICSW Medical Directors make all denial of coverage determinations. Any person making decisions on UM, including formulary coverage determinations are based on meeting criteria for appropriateness of care and services and are subject to the terms and limitations of the Insurance Policy. SWHP/ICSW does not offer incentives, including compensation or rewards, to Practitioners or other individuals conducting utilization review to encourage denials of coverage of services or offer financial incentives that encourage decisions that result in underutilization of services. SWHP/ICSW does not use incentives to encourage barriers to care and services.

Medical Director(s) compensation is not based on utilization of services denials. SWHP/ICSW does not make decisions regarding hiring, promoting or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

SWHP/ICSW monitors for evidence of underutilization, overuse, and misuse through the Quality Improvement (QI) Committee's review of MEDInsight reports, HEDIS® measures, QI Team measures and complaint data. Evidence of underutilization, overutilization and misuse will be discussed with the individual physician, as well as targeted Member outreach as appropriate. Individual coverage requests are discussed with the individual physicians/providers making the request on behalf of a Member.

SWHP/ICSW UM Staff, including Medical Directors, are available by telephone 24 hours per day, 7 days per week or by appointment at 1-254-298-3088 or toll free at 1-888-316-7974. The staff is available

Care Coordination Division (CCD)

to discuss UM and/or coverage determinations, including benefit provisions, guidelines, criteria or the processes used to make determinations. The SWHP/ICSW "on call" nurse who has access to a SWHP/ICSW Medical Director on call is available after hours.

Appeal rights, including expedited appeals, reconsideration rights and/or Independent Review Organization (IRO) options are always provided with any denial issued. Practitioners may request to review criteria at any time including at the time of a case-specific determination. Criteria will be provided by fax, phone, and email or through an onsite appointment with the Care Coordination Division (CCD) management staff. CCD can be reached by calling the toll free number at 1-888-316-7947 or directly at 1-254-298-3088.

In an effort to improve communication with non-English speaking Members, SWHP/ICSW uses the interpretive services of AT&T. Members do not have to call a special line for this service. When contacting SWHP/ICSW, Members may notify the CCD staff and/or Customer Advocates of their primary language and the call will be completed with the help of an AT&T interpreter at no charge to the Member. CCD Staff follows established internal SWHP/ICSW policies related to provision of interpretive services for SWHP/ICSW Members.

SWHP/ICSW utilizes a toll free TTY number 1-800-735-2989 to assist with communication services for Members with hearing or speech difficulties. The TTY number is listed on the SWHP webpage at www.swhp.org and is also included in your Member correspondence and Member publication materials.

SCOTT & WHITE HEALTH PLAN

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