



OPNS GUIDELINES FOR UNMET MEASURES REPORTS

Subject: Office Utilization Procedure for Unmet Quality/HEDIS Measures Reports

Statement of Purpose: OPNS provides periodic Unmet Quality/HEDIS Measures Reports to physician offices to facilitate better patient outcomes, reduce health care costs and maximize physician incentive rewards payment. These guidelines provide action steps for offices to most effectively utilize these reports.

Procedure:

1. CHECK THE REPORT FOR PATIENT ELIGIBILITY:

- **Review the provided data for patient eligibility.** Compare patient names on the report to your monthly eligibility lists or go on line to check eligibility with the specific health plan... (See attached health plan information for access to Provider Services.)
- **Notify the health plans** of any patients on the Unmet Measures Report not assigned to you and have them removed from your Quality Patient Panel.
- **Contact by telephone or mail** all patients assigned to you but never seen in the office or delinquent in their office visits. **Schedule office visits** to update quality measures. If patients have been assigned to your office against their wishes, advise them to contact the health plan to change to a physician better able to serve their needs. Remember you are responsible for the care of patients as long as they remain on your patient panel.
- **Document in the patient's chart** attempts to schedule office visits.

2. REVIEW THE REPORT FOR ACCURACY:

- **Review the patient chart for evidence the unmet measure was completed.**
- **Submit documentation of provided services to the appropriate health plan.** (See data submission procedure on the attached health plan information sheet) Often a measure will be listed as unmet because the result of the test is not known even though the date it was administered may be. By submitting the test result it will be removed from your Patient Unmet Measures Panel. Some measures, such as Lead Screens, require 2 tests. The measure will not be removed from your unmet measures panel until both tests have been completed.
- **Bill correctly and submit to MCIR, where appropriate, all quality/preventative services provided in the office.** By billing services provided, whether you are paid for them or not, health plans are able to capture data for quality reporting and incentive purposes.

3. UTILIZE THE REPORT TO ADDRESS UNMET MEASURES:

- **Contact by telephone or letter those patients with unmet measures and schedule the appropriate office visit and/or service.** Consider sending a requisition form for needed tests or services with the letter to make it easier for patients to comply.
- **Create a follow up process or “tickler file”** to monitor the effectiveness of office reminder efforts. Remove patients as they are seen or services provided. Check the file periodically for patients not responding to a call or letter and make a second attempt to schedule the necessary office visit or test.
- **Document in the chart all efforts to contact and engage the patient.** Many plans have a process for removing non-compliant patients so they no longer impact a physician’s quality scores. Documentation of your efforts to engage the patient will be necessary in this process.



OPNS GUIDELINES FOR UNMET MEASURES REPORTS IMPLEMENTATION INFORMATION

BLUE CROSS BLUE SHIELD of MICHIGAN PPO

CHECKING THE REPORT FOR PATIENT ELIGIBILITY:

- To confirm a patient has BCBSM PPO insurance: verify through **BCBSM's web-DENIS, Subscriber Information/Eligibility Coverage COB website**
- Since PPO members are not assigned to a PCP, BCBSM attributes responsibility for a patient's unmet quality measures to the physician/specialist with the most office visit claims in the measurement year. If a service is outside a physician's scope of practice, the patient should be informed of the needed service and referred to the most appropriate provider.

REVIEWING THE REPORT FOR ACCURACY:

- Submitting or correcting Unmet Measures data:
 - 1) Immunizations:** Check MCIR to be sure immunizations were submitted correctly. Verify immunizations were properly billed and re-bill if necessary.
 - 2) Tests and lab results:** Submit data to MCIR, where appropriate, and check that billing was properly provided for all office tests and procedures. BCBSM advises to **bill for all tests and procedures** even if not reimbursed. The billing signals BCBSM to credit the office for appropriate incentive rewards.
- Submitting or correcting **Well Child and Adult Office Visits** data:
 - 1)** Check to see if the visit was billed correctly and if it was not, **re-bill**.
 - 2)** When comprehensive Well Child Visits are done simultaneously with a Sick Visit, be sure to **bill for only one of the visits, preferably the Well Child Visit. BCBSM does not permit billing for both visits.**



OPNS GUIDELINES FOR UNMET MEASURES REPORTS IMPLEMENTATION INFORMATION

BLUE CARE NETWORK

CHECKING THE REPORT FOR PATIENT ELIGIBILITY:

- To verify a patient belongs to you: check your monthly BCN Eligibility Lists or verify on **BCBSM's web-DENIS, Subscriber Information/Eligibility Coverage COB website.**
- If a patient is not assigned to you: contact **PROVIDER SERVICES: 800-255-1690** to have the patient removed from your Quality Patient Panel. Patients remain your responsibility as long as they are on your patient panel.

REVIEWING THE REPORT FOR ACCURACY:

- Submitting or correcting Unmet Measures data:
 - 1) Immunizations:** Check MCIR to be sure immunizations were submitted correctly. Verify immunizations were properly billed and re-bill if necessary. Submit immunization dates to the appropriate immunization measure in the **Health e-Blue (Heb)** Treatment Opportunities by Condition/Measure Panel.
 - 2) Tests and lab results:** Check **Health e-Blue** to be sure dates and results have not already been received and credited to you. If not, **enter the missing test or lab results in the HeB** Treatment Opportunities by Condition/Measure Panel. Be sure to also submit data to MCIR, where appropriate, and properly bill for the test or procedure. BCN advises to **bill for all tests and procedures** even if you do not get paid for them. The billing signals BCN to credit the office for appropriate incentive rewards.
- Submitting or correcting **Well Child and Adult Office Visits** data:
 - 1)** Check to see if the visit was billed correctly and if it was not, **re-bill.**
 - 2)** When comprehensive Well Child Visits are done simultaneously with a Sick Visit, be sure to **bill for only one of the visits, preferably the Well Child Visit. BCN does not permit billing for both visits.**



OPNS GUIDELINES FOR UNMET MEASURES REPORTS IMPLEMENTATION INFORMATION

HEALTH PLAN OF MICHIGAN

CHECKING THE REPORT FOR PATIENT ELIGIBILITY:

- To verify a patient belongs to you: check your monthly HPM Eligibility Lists or verify on **HPM's WEB CLIENT eligibility verification data base.**
- If a patient is not assigned to you: contact **PROVIDER SERVICES: 888-773-2647** to have the patient removed from your Quality Patient Panel. Patients remain your responsibility as long as they are on your patient panel.

REVIEWING THE REPORT FOR ACCURACY:

- Submitting or correcting Unmet Measures data:
 - 1) Immunizations:** Check MCIR to be sure immunizations were submitted correctly. Verify the immunizations were properly billed and re-bill if necessary. A billing code of 0 must accompany immunizations when the vaccines being used are received at no cost from the State of Michigan through the VFC program.
 - 2) Tests and lab results:** All screens and test results, including lead screen results, may be submitted to **HPM QUALITY SERVICES : Fax # 313-202-0006.** Be sure to also submit data to MCIR, where appropriate, and properly billed for the test or procedure. HPM advises to **bill for all tests and procedures** even if you do not get paid for them. The billing signals HPM to credit the office for appropriate incentive rewards.
- Submitting or correcting **Well Child and Adult Office Visits** data:
 - 1)** Check to see if the visit was billed correctly and if it was not, **re-bill.**
 - 2)** When comprehensive Well Child Visits are done simultaneously with a Sick Visit, **bill for both visits**, adding a Modifier 25 code to the Sick Visit. This alerts HPM that a comprehensive Well Child Visit was also done and credits the office.



OPNS GUIDELINES FOR UNMET MEASURES REPORTS IMPLEMENTATION INFORMATION

PRIORITY HEALTH

CHECKING THE REPORT FOR PATIENT ELIGIBILITY:

- To verify a patient belongs to you: check your monthly Priority Eligibility Lists or verify on the **Patient Profile portal on Priority's internet website**.
- If a patient is not assigned to you: contact **PROVIDER SERVICES: 800-942-4765** to have the patient removed from your Quality Patient Panel. Members remain your responsibility as long as they are on your patient panel.

REVIEWING THE REPORT FOR ACCURACY:

- Submitting or correcting Unmet Measures data:
 - 1) Immunizations:** Check MCIR to be sure immunizations were submitted correctly. Verify immunizations were properly billed and re-bill if necessary. Enter immunization data to the appropriate immunization measure under Patient Profile/Patient Health Conditions on the Priority website.
 - 2) Tests and lab results:** Check **Patient Profile/Patient Health Conditions** on the Priority website to be sure dates and results have not already been received and credited to you. If not, **enter the missing test or lab results in the Patient Profile data base**. Be sure to also submit data to MCIR, where appropriate, and properly bill for the test or procedure. Priority advises to **bill for all tests and procedures** even if you do not get paid for them. The billing signals Priority to credit the office for appropriate incentive rewards.
- Submitting or correcting **Well Child and Adult Office Visits** data:
 - 1)** Check to see if the visit was billed correctly and if it was not, **re-bill**.
 - 2)** When comprehensive Well Child Visits are done simultaneously with a Sick Visit, be sure to **bill for both visits**.



OPNS GUIDELINES FOR UNMET MEASURES REPORTS IMPLEMENTATION INFORMATION

GREAT LAKES HEALTH PLAN

CHECKING THE REPORT FOR PATIENT ELIGIBILITY:

- To verify a patient belongs to you: check your monthly GLHP Eligibility Lists or verify on **GLHP's OSCR eligibility verification data base.**
- If a patient is not assigned to you: contact **PROVIDER SERVICES: 800-903-5253** to have the patient removed from your Quality Patient Panel. Patients remain your responsibility as long as they are on your patient panel.

REVIEWING THE REPORT FOR ACCURACY:

- Submitting or correcting Unmet Measures data::
 - 1) Immunizations:** Check MCIR to be sure the immunizations were submitted correctly. Verify the immunizations were properly billed and re-bill if necessary. A billing code of 0 must accompany immunizations when the vaccines being used are received at no cost from the State of Michigan through the VFC program. GLHP states: "Data not captured by MCIR or billing claims is in question," so both steps are essential in receiving credit for immunizations.
 - 2) Tests and lab results:** Check OSCR to be sure result has not been received. Submit documentation of test results, including lead screen results, to **GLHP's Stephanie Esters** at: **Fax # 248-331-4519**. Be sure to also submit data to MCIR, where appropriate, and properly billed for the test or procedure. GLHP advises to **bill for all tests and procedures** even if you do not get paid for them. The billing signals GLHP to credit the office for appropriate incentive rewards.
- Submitting or correcting **Well Child and Adult Office Visits** data:
 - 1)** Check to see if the visit was billed correctly and if it was not, **re-bill with a 7 in box 22.**
 - 2)** When comprehensive Well Child Visits are done simultaneously with a Sick Visit, **bill for both visits**, adding a Modifier 25 code to the sick visit. This alerts GLHP that a comprehensive Well Child Visit was also done and credits the office.



OPNS GUIDELINES FOR UNMET MEASURES REPORTS IMPLEMENTATION INFORMATION

HEALTH ALLIANCE PLAN

CHECKING THE REPORT FOR PATIENT ELIGIBILITY:

- To verify a patient belongs to you: check your monthly HAP Eligibility Lists or verify on HAP's website, www.hap.org, Online Network Services, "Verify Member Eligibility".
- If a patient is not assigned to you: the patient needs to be instructed to contact HAP PROVIDER SERVICES: 313-872-8100 or the number on their card to be assigned to you or reassigned to the physician of their choice. Patients will remain your responsibility as long as they are on your patient panel.

REVIEWING THE REPORT FOR ACCURACY:

- Submitting or correcting Unmet Measures data:
 - 1) **Immunizations:** Check MCIR to be sure immunizations were submitted correctly. Verify immunizations were properly billed and re-bill if necessary. Submit immunization dates from sources other than your office to the member's HAP record on the website's **Member Health Manager (MHM) panel**.
 - 2) **Tests and lab results:** There are other methods to report missing lab values and services to HAP, other than claims, which can improve your HEDIS rates. **Online reporting:** Click on the **Lab Data Entry Application** to report missing lab data for a member and the **Member Health Manager Application** to report things like B/P levels, diabetic foot exams and misidentified chronic conditions.
- Submitting or correcting **Well Child and Adult Office Visits** data:
 - 1) Check to see if the visit was billed correctly and if it was not, **re-bill**.
 - 2) When comprehensive Well Child Visits are done simultaneously with a Sick Visit, be sure to **bill for only one of the visits, preferably the Well Child Visit**. HAP **does not permit billing for both visits**.