Provider Guide: Closing Care Gaps

Providers deserve to be rewarded for the excellent care they provide to Carolina Complete Health members. This guide reviews the options providers have for closing HEDIS care gaps.

Part 1: What to Send

For a care gap to close, members in the measure must receive required services or have evidence of a NCQA technical specification identified contraindication. Therefore, it is good practice to send both numerator services and contraindications. For example, for Cervical Cancer Screening (CCS), cervical cytology, hrHPV testing or co-testing within the last 5 years, as well as total hysterectomies anytime in the member's history should be sent.

Measure specific Dx and Proc codes can be found in the Quality Measures Training **slide deck** on the CCH Network website. The slide deck also includes helpful tips to capture compliance. For example, for Controlling High Blood Pressure (CBP), if the BP reading is high at the beginning of the visit, retake it at the end of the visit and record the lowest systolic and diastolic readings.

Part 2: Billing & CPT II Codes

Carolina Complete Health encourages providers to bill for all services provided. This includes billing the appropriate CPT II codes at the time of service to capture clinical components of care (blood pressures, lab results). For appropriate billing codes for each measure, reference the **HEDIS quick reference guide** and the Tip Sheets at the **Carolina Complete Health Network website**. Claims are processed as they are received, and care gap closure will be seen in 30-45 days or less.

Part 3: Standard Supplemental Files

Carolina Complete Health can process supplemental data using a standard file format. For times when providers cannot bill services i.e. the service was performed in a prior year, Carolina Complete Health can utilize supplemental data to impact Quality measure rates. This is helpful for measures where the lookback period is longer. As mentioned above, Cervical Cancer Screening (CCS) measure looks back as much as 5 years for compliance and anytime in the member's history for an exclusion.

Depending on the volume of care gaps, standard flat files are often the best option to improve rates. Providers can work with Centene's Supplemental Data Setup (SDS) team to understand the requirements around generating a flat file. These files can capture clinical information that would otherwise not be billed, as well as historical services. Carolina Complete Health works closely with providers to identify what data to send, sharing best practices and providing technical feedback. While setting up a supplemental flat file can take time, the initial investment is worth it. Setting up a supplemental data file is a onetime investment, afterwards, files can be sent and considered monthly. Files are processed as they are received, so gap closure can be seen in 30-45 days or less, similar to claims. Please view the **Supplemental Data (SUDS) Implementation Guide** to support you in facilitating the automated submission of Supplemental Data. Let your CCH Provider Engagement Coordinator know if you are interested in setting up a supplemental data feed.

Part 4: EMR Access

Access to a provider's EMR allows Carolina Complete Health to review medical records for critical gaps. This access is complimentary to billing, as well as standard supplemental files and allows remaining gaps to be addressed. Access to a provider's EMR can decrease the administrative burden of medical record requests to the provider. Let your CCH Provider Engagement Coordinator know if this is feasible and provide instructions on how to access your EMR.

Part 5: Medical Records

For a small volume of care gaps, charts with relevant services can be sent to Carolina Complete Health through the provider portal. However, services captured in health records is resource intensive, time sensitive and subject to manual error. Additionally, medical record data is considered non-standard supplemental data and therefore must pass a yearly audit. Failure of this audit will mean that all charts from this source cannot be considered in final rates. Non-standard supplemental data will have delayed impact on measure rates due to the needed quality assurance steps taken, with compliance reflected 60-90 days after the chart is sent. Due to audit processes, charts will be processed June through December. Charts sent after December 1st will not be ingested for rate update.

Providers can submit these records via the provider portal. Providers are encouraged to not send the entire chart, but only the section of the chart documenting the relevant service.

The naming convention for the medical record is Last Name First Name DOB. So, the file name for Jane Smith born 02/14/1989 would be SMITH JANE 02141989

The steps to submit a HEDIS record on the portal are below. The Submission Reason would be the measure impacted by the patient chart.

1. Select **Quality Management** for the Document Category.
2. Select **HEDIS** in the Document Type.
3. Select applicable Submission Reason from the options in the drop-down.
4. Choose the file for upload (making sure to follow the file naming convention, mentioned above).
5. Click “Submit.”