MetroPulse provider newsletter

SPRING 2018

MEDICARE DIABETES PREVENTION PROGRAM

As of April 1, MetroPlus Medicare and FIDA members have access to the new Medicare Diabetes Prevention Program (MDPP) benefit.

The MDPP is a structured intervention with the goal of preventing progression to type 2 diabetes in individuals with an indication of prediabetes. The MDPP benefit allows Medicare beneficiaries to access evidence-based diabetes prevention services, with the goal of a lower rate of progression to type 2 diabetes, improved health, and reduced spending. This is an expansion of the Diabetes Prevention Program (DPP) model test. The clinical intervention consists of a minimum of 16 intensive "core" sessions of a Centers for Disease Control and Prevention (CDC) approved curriculum furnished over six months in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. After completing the core sessions, less intensive follow-up meetings furnished monthly will help ensure that participants maintain healthy behaviors. The primary goal of the expanded model is at least 5 percent weight loss by participants.

For information on how to enroll in the MDPP, including an FAQ, application, and timeline, visit https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/

For information about enrolling in the MDPP, click here.

Other information is available online, including:

- MDPP Enrollment Fact Sheet
- MDPP Enrollment Checklist
- MDPP Enrollment Application
- MDPP Enrollment Process Timeline

IN NETWORK LAB USAGE

MetroPlus would like to remind providers that you should refer your MetroPlus patients to in-network labs. This will ensure members will not be billed for out of network services.

To check if a lab is in-network, you can use the "Find a Doctor" page on our website, check an online provider directory, or call Member Services.

PROVIDER PORTAL UPDATE

The MetroPlus provider portal has launched a new update to the eligibility search. Now, when utilizing the Member Family Information Search, you can view the Recertification Due Date for each member. We encourage you to remind patients of upcoming recertification deadlines, in order to ensure that they remain members of MetroPlus and continue to have access to care.

PHARMACEUTICAL MANAGEMENT PROCEDURES

As part of our Utilization Management program, MetroPlus Members must fulfill certain prerequisites before certain medication are covered. These restrictions are in place for numerous reasons including safety, or when medications are only approved for use in very specific or limited instances.

Every MetroPlus product has its own formulary and therefore has its own utilization management rules. These rules can be PA/prior authorization (prescriber must submit supporting documentation), ST/step therapy (member must try certain formulary medications before another medication is allowed) and QL/quantity limits (medication is restricted to a certain amount over a specific timeframe and anything exceeding that would require an approval).

More information, including our criteria for the different rules, can be found in the Formularies section of our website (https://www.metroplus.org/member-services/formularies).

WHY YOU SHOULD DISCUSS BMI WITH YOUR PATIENTS

When used correctly, Body Mass Index (BMI) can be an excellent tool for screening patients for obesity and its health risks. BMI is easy to calculate using inexpensive and noninvasive measures, and BMI levels correlate with body fat and future health risks.

BMI should serve as an initial screening to identify potential weight problems for adults. Other factors, such as fat distribution, fitness level, and age, should also be considered when assessing an individual patient's disease risk.

For more information, you can visit the CDC's website at: https://www.cdc.gov/obesity/downloads/bmiforpactitioners.pdf

ASTHMA MANAGEMENT/ASTHMA MEDICATION ADHERENCE

Asthma is a serious condition that can be controlled with medication—but some patients do not adhere to their treatment plans. Here are some key steps you can take to encourage a partnership with patients and their families:

- Develop a written asthma action plan with the patient to agree on treatment goals. Having an asthma action plan can help to encourage medication adherence and reinforce education about their condition.
- When choosing treatments, consider the patient's history of use and willingness and ability to adhere to the recommended treatment plan.
- Recommend ways that patients can control their exposure to conditions that make their asthma worse (allergens, irritants, pollutants).
- Encourage patients to treat comorbid conditions (including receiving flu shots).
- If your patient is pregnant, make sure to check on asthma at prenatal visits. Pregnancy can cause a patient's asthma to improve or worsen, and adjusting medication may be necessary.

WELL CHILD VISITS: BIRTH TO 15 MONTHS

By the time a child is 15 months old, they should have attended at least six well child visits. Providers should remind guardians of the need for multiple visits and encourage scheduling of future appointments in advance.

At this early age, it is especially crucial to maintain proper documentation of visits. The child's medical record should include:

- Visit date
- Health history
- Mental and physical developmental history
- Specific health education/ anticipatory guidance
- Physical examination and measurements, such as weight, length, head circumference, blood pressure
- Procedures, such as immunizations, hematocrit, or hemoglobin
- Preventive services, such as vision, dental, or hearing
- Physician signature

MANAGEMENT OF CHRONIC CONDITIONS

Chronic conditions affect patients in every age group. Unmanaged, or poorly managed, chronic conditions often lead to serious complications for patients and their families. Regardless of the condition, chronic conditions present challenges for patients, including:

- Dealing with symptoms
- Disability
- Complex medication regimes
- Difficult lifestyle adjustments
- Access needed care and services

TIPS FOR PROVIDERS:

- Deliver care based on recognized clinical guidelines. Clinical Practice Guidelines help by providing evidence-based recommendations for the evaluation and treatment of select common conditions. The MetroPlus Clinical Practice Guidelines are updated regularly, and can be found on the provider portal.
- Consider the goals of patients/caregivers and promote realistic and specific self-management activities.
- Provide personalized culturally sensitive care (cookie cutter approaches do not work). Managing chronic conditions will require patient/caregiver buy-in.
- Develop a plan of care that includes teaching patients/caregivers early warning signs and what actions to take (i.e. when to call you, when to go to an urgent center verses the emergency room).
- Provide coordinated care, including all members of the health care team (nursing staff, care managers, specialist, pharmacist).
- Please visit our provider portal for additional information regarding clinical practice guidelines.

IMPROVING AND MAINTAINING PHYSICAL AND MENTAL HEALTH IN OLDER ADULTS

As patients age, it is important to encourage them to remain active. Older Americans are a rapidly growing age group, but are among the least active. The benefits of regular physical activity include a reduced risk of cardiovascular disease, certain types of cancer, osteoporosis, and obesity. Beyond the physical benefits, exercise can assist with managing mental health conditions, such as depression and anxiety. There is also some evidence that regular physical activity can prevent or delay cognitive impairment.

Encourage patients to reduce sedentary behavior, and take a gradual approach. Activities that focus on balance can help patients who may be at risk of falls. All patients can benefit from moderate intensity aerobic activity, muscle strengthening exercises, and activities that maintain or increase flexibility.

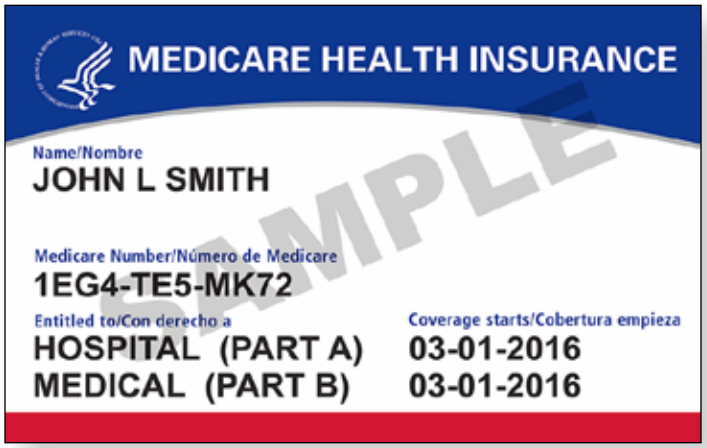
OFFICE WAITING TIME STANDARDS

Please remember that excessive office waiting time affects the overall member satisfaction with the provider and the health plan. Please follow up with these standards, which are listed in our MetroPlus *Provider Manual*:

- **Waiting room times must not exceed one (1) hour for scheduled appointments.**
- **Members who walk in with urgent needs must be seen within one (1) hour.**
- **Members who walk in with non-urgent "sick" needs must be seen within two hours or must be scheduled for an appointment to be seen within 48 to 72 hours, as clinically indicated.**

5 WAYS FOR HEALTHCARE PROVIDERS TO GET READY FOR NEW MEDICARE CARDS

Medicare is taking steps to remove Social Security numbers from Medicare cards. Through this initiative the Centers for Medicare & Medicaid Services (CMS) will prevent fraud, fight identity theft and protect essential program funding and the private healthcare and financial information of our Medicare beneficiaries.



CMS will issue new Medicare cards with a new unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI) to replace the existing Social Security-based Health Insurance Claim Number (HICN) both on the cards and in various CMS systems we use now. CMS will start mailing new cards to people with Medicare benefits in April 2018. All Medicare cards will be replaced by April 2019.

CMS is committed to helping providers by giving them the tools they need and making this process as easy as possible for you, your patients, and your staff. Based on feedback from healthcare providers, practice managers and other stakeholders, CMS is developing capabilities where doctors and other healthcare providers will be able to look up the new MBI through a secure tool at the point of service. To make this change easier for you and your business operations, there is a 21-month transition period where all healthcare providers will be able to use either the MBI or the HICN for billing purposes.

Therefore, even though **your systems will need to be able to accept the new MBI format by April 2018**, you can continue to bill and file healthcare claims using a patient's HICN during the transition period. Work with your billing vendor to make sure that your system will be updated to reflect these changes as well.

Beginning in April 2018, Medicare patients will come to your office with new cards in hand.

HERE ARE 5 STEPS YOU CAN TAKE TODAY TO HELP YOUR OFFICE OR HEALTHCARE FACILITY GET READY:

1. Go to the CMS provider website and sign up for the weekly MLN Connects® newsletter.
2. Attend the CMS quarterly calls to get more information. The call schedule is included in the MLN Connects newsletter.
3. Verify all of your Medicare patients' addresses. If the addresses you have on file are different than the Medicare address you get on electronic eligibility transactions, ask your patients to contact Social Security and update their Medicare records.
4. Help your Medicare patients adjust to their new Medicare card. When available later this fall, you can display helpful information about the new Medicare cards. Hang posters about the change in your offices to help us spread the word.
5. Test your system changes and work with your billing office staff to be sure your office is ready to use the new MBI format.

CMS wants to work closely with you to answer your questions and hear your concerns. To learn more, visit: cms.gov/Medicare/SSNRI/Providers/Providers.html

PROPER DOCUMENTATION AND CODING

Complete, accurate patient records are necessary to encourage quality and continuity of care. It creates a means of communication between different providers, and between providers and members, about health status, preventive services, treatment, planning, and delivery of care.

REQUIREMENTS:

- Keep a unique, individual record for each patient
- Establish an organized record-keeping system to ensure that medical records are easily retrievable for review and available for use when needed, including at each patient visit
- Store and maintain medical records in a centralized and secured location accessible only to authorized personnel and provide equivalent security for electronic medical records
- Maintain and organize documents within medical records in a specified order
- Ensure that documents are fastened securely within a paper medical record
- Provide periodic training in confidentiality and security for patient information

CODING:

Refer to each specific code set for instructions in using these codes appropriately. Some basic coding rules to keep in mind are:

- Use only codes that are valid for the date of service.
- Link CPT codes to revenue codes when required.
- Follow OCE edit guidelines where required.
- It's important to follow all guidelines for diagnosis coding. Special attention should be given to the following requirements:
- Diagnosis codes should be coded to the highest specificity required for each code.
- Refer to ICD-9 (ICD-10) guidelines in determining if a diagnosis code can be billed in the primary position, secondary position or either position.

It is important that all usage of patient records emphasize confidentiality and allow access by authorized users only.

Access and Availability Standards

MetroPlus Members must secure appointments within the following time guidelines:

Emergency Care	Immediately upon presentation
Urgent Medical or Behavioral Problem	Within 24 hours of request
Non-Urgent "Sick" Visit	Within 48 to 72 hours of request, or as clinically indicated
Routine Non-Urgent, Preventive or Well Child Care	Within 4 weeks of request
Adult Baseline or Routine Physical	Within 12 weeks of enrollment
Initial PCP Office Visit (Newborns)	Within 2 weeks of hospital discharge
Adult Baseline or Routine Physical for HIV SNP Members	Within 4 weeks of enrollment
Initial Newborn Visit for HIV SNP Members	Within 48 hours of hospital discharge
Initial Family Planning Visit	Within 2 weeks of request
Initial Prenatal Visit 1st Trimester	Within 3 weeks of request
Initial Prenatal Visit 2nd Trimester	Within 2 weeks of request
Initial Prenatal Visit 3rd Trimester	Within 1 week of request
In-Plan Behavioral Health or Substance Abuse Follow-up Visit (Pursuant to Emergency or Hospital Discharge)	Within 5 days of request, or as clinically indicated
In-Plan Non-Urgent Behavioral Health Visit	Within 2 weeks of request
Specialist Referrals (Non-Urgent)	Within 4 to 6 weeks of request
Health Assessments of Ability to Work	Within 10 calendar days of request

MetroPlus Health Plan
plan ahead.
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CHANGES TO YOUR DEMOGRAPHIC INFORMATION

Notify MetroPlus of any changes to your demographic information (address, phone number, etc.) by calling your Provider Service Representative. You should also notify MetroPlus if you leave or join a new practice. Changes can also be faxed in writing on office letterhead directly to MetroPlus at **212.908.8885**. You can also call **1.800.303.9626** with changes.

METROPLUS COMPLIANCE HOTLINE

MetroPlus has its own Compliance Hotline: **1.888.245.7247**. You may call this line to report suspected fraud or abuse, possible illegal activities and questionable activity. You may choose to give your name, or you may report anonymously.

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