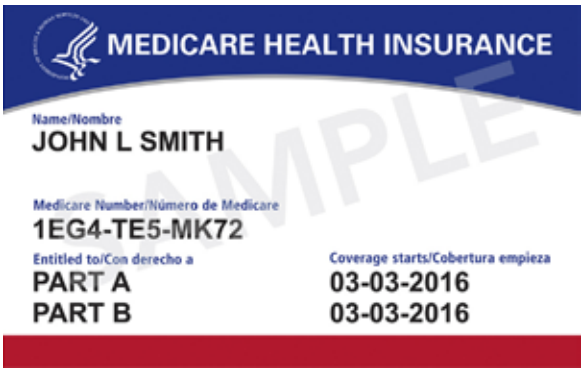
MetroPulse provider newsletter

SUMMER 2018

NEW MEDICARE CARD: MBI LOOK-UP TOOL AVAILABLE

New Medicare Card



This summer, Medicare members are receiving new Medicare cards with new Member Beneficiary Identifier (MBI) numbers. There are three ways to get a patient's new MBI:

- Check the patient's Medicare card. Residents of New York should start receiving their new cards after June.
- Use the new online MBI look-up tool. You can access the new portal here to find a patient's MBI.
- Beginning in October, Medicare will include the MBI on every remittance advice when claims are submitted with valid, active HICINs.

You can start using these new MBIs immediately. Beginning on January 1, 2020, using the new MBIs will be mandatory.

For more information from CMS, click here.

RA CODING REMINDER

As you know, correctly coding the treatment a patient receives is crucial for tracking quality of care and for determining the severity of illness.

Here are some tips for meeting the HEDIS requirements for disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (RA):

DMARD-HCPS: J0129, J0135, J0717
Exclusions: HIV-ICD10: B20, Z21, ICD9: 042, V08
Pregnancy-ICD10: O00.0, O00.1, O00.2

- Adults who are 18 years and older, and have been diagnosed with RA, should be dispensed at least one prescription for a disease modifying anti-rheumatic drug (DMARD).
- Do NOT use Rheumatoid Arthritis diagnosis codes when ruling out the disease.
- Exclusions: Patients with HIV Diagnosis or who are Pregnant during the measurement year
- For more information about HEDIS coding, click here. The HEDIS measures for RA are listed under the code "ART".

BEHAVIORAL HEALTH FOLLOW UP CARE

Follow up is critical for any member seen in the emergency room for mental health or substance abuse. Members seen for follow up are more likely to have better outcomes.

Whether a patient is discharged from an emergency room or an inpatient stay, the follow up should occur within seven days. If you are not sure where to refer a member for Behavioral Health services please contact our Behavioral Health vendor, Beacon Health Options at **1.888.204.5581**.

EPDST FOR CHILDREN

Children under age 21 who are enrolled in Medicaid are eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPDST) benefit.

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
- **Treatment:** Control, correct or reduce health problems found.

When coding for EPDST, it is important to use acceptable documentation.

Nutritional Counseling: Use ICD-10 informational code Z71.3.

Acceptable Documentation	Unacceptable Documentation
Discussion of current nutritional behaviors (habits and behavior)	Documentation of appetite alone
Documentation of quality and type of diet	Physical finding or observation alone
Educational materials provided during face-to-face visit	Educational materials provided via email, or instruction to patients to research alone
Anticipatory guidance for nutrition	General anticipatory guidance without reference to nutrition
Weight or obesity counseling	Documentation of behavior without mention of nutrition
Referrals provided to food and nutrition program	Specific diet prescribed for a condition (BRAT, ADA)
Counseling or referral for nutrition education	Questionnaires completed by parents without review by provider
Checklist indicating that nutrition was addressed	Unmarked checklist

Physical Activity Counseling: Use ICD-10 informational code Z71.82.

Acceptable Documentation	Unacceptable Documentation
Discussion of physical behavior (sports, exercise)	Documentation of "plays with peers" with no other mention of physical activity
Completion of sports physical exam	Note that patient can participate in gym class without documentation
Educational materials provided during face-to-face visit	Educational materials provided via email, or instruction to patients to research alone
Anticipatory guidance for physical activity	General anticipatory guidance without reference to physical activity
Weight or obesity counseling	Reference to decreased time using tv/computer without mentioning physical activity
Counseling or referral for physical activity	Specific activities prescribed for injuries or conditions (physical therapy)
Bike and water safety discussion with specific recommendations of activities	Note of anticipatory guidance for safety without mention of physical activity
Checklist indicating that physical activity was addressed	Unmarked checklist

WHAT IS TRANSITION OF CARE MANAGEMENT?

Transition of Care (TOC) Management provides coordination and continuity of care for members transitioning from an inpatient facility setting to other care settings. A **Care Manager** (with or without support from an in-home contracted and credentialed medical provider) will support the member through the transition process by providing discharge support and coordination including self-management skills, medication reconciliation and medication adherence, enhanced care coordination of care for all member needs, and facilitation of follow up visits.

The **Care Manager (CM)** is notified of inpatient admissions via the care management system, facility notification (discharge planner) and admission census. Discharge planning is initiated by the CM upon admission notification to foster timely transition of members. The CM actively participates in the member's transition and communicates with the member and/or caregiver throughout the transition process. The CM helps with the following:

- Arrangement for transportation
- Coordination of post discharge services
- Identification of appropriate level of post-acute care, including the appropriate provider, facility and available services
- Identification of patient and family preferences for post-acute care
- Facilitation of admissions from one care setting to another (home, community, hospital, nursing home, or out of area)
- Coordination of financial resources and payers
- Assist providers, members and their families with alternative care options
- Interpretation of benefit coverage and identification of non-covered benefits for providers/members
- Act as a resource and facilitator for hospital and providers to facilitate authorization for care based on medical necessity and medical needs
- Facilitate the availability of health care information needed to coordinate care

The TOC manager is focused on improving quality of care and preventing avoidable admissions, readmissions and emergency room visits. Members receive transitional care management for 90 days post hospitalization or subacute/rehab admissions. Members who continue to have needs after the transitional period receive comprehensive care management.

If you have a member who you think would benefit from care management, contact **1.800.579.9798**.

DIABETES CARE GUIDELINES AND RECOMMENDATIONS

The American Diabetes Association (ADA) has released the *2018 Standards of Medical Care in Diabetes*. The *Standards of Care* exists to provide information about diabetes, treatment goals, and tools to evaluate patient care. The *Standards* includes the most current evidence-based recommendations for diagnosing and treating adults and children with diabetes, including grades to show the level and quality of evidence supporting each recommendation.

The ADA has also released an Abridged version of the *Standards of Care*, focused on providing information to PCPs who treat adults and children with diabetes.

Some of the recommendations in the *Standards of Care* include:

- Utilizing team-based care and community involvement
- Screening for prediabetes (an increased risk of diabetes)
- Assessing comorbidities
- Encouraging lifestyle management by patients (including weight management and nutrition therapy)

The full and abridged *Standards of Care* are available on the ADA's website. More information can also be found on the MetroPlus website.

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 these standards, which are listed in our MetroPlus *Provider Manual* under "Office Waiting Time Standards":

- **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.**

IMMUNIZATIONS FOR ADOLESCENTS

Adolescence is a crucial time for patients to be vaccinated. Adolescents should receive:

- Meningococcal conjugate vaccine
- Tdap (tetanus, diphtheria toxoids, and acellular pertussis) vaccine

Adolescents should also receive the HPV vaccine. HPV vaccinations should be given between the member's 9th and 13th birthdays, on one of two schedules:

- Two vaccines with different dates of service
- Three vaccines with different dates of service

How can you make sure your patients are fully vaccinated? Use every appointment to recommend vaccines to the parents of your patients. Avoid missed opportunities by recommending the HPV vaccine the same way and on the same day as the other adolescent vaccines. Educate parents about the diseases that can be prevented through adolescent vaccinations and talk about the HPV vaccination in terms of preventing cancer.

The CDC has many HPV resources for clinicians, including a guide on answering questions that parents of patients may have. Visit cdc.gov/hpv for more information.

OPIOID PRESCRIPTION GUIDELINES

MetroPlus encourages our providers to follow the CDC *Guidelines for Prescribing Opioids for Chronic Pain*. The CDC has developed these guidelines to provide recommendations for PCPs who prescribe opioids for chronic pain (outside of treatment for cancer and palliative and end of life care).

The CDC *Guidelines* aim to improve communications between providers and patients about using opioid therapy for chronic pain. These new guidelines emphasize assessing risks and harms to individual patients (not just "high risk" patients). It is important to monitor patients' use of opioids and exercise caution when prescribing the dosages.

A summary of the *Guidelines* is available on the CDC website at www.cdc.gov/drugoverdose/prescribing/guideline.html

A complete version of the CDC *Guidelines* is also available at the MetroPlus provider Portal at https://providers.metroplus.org/my.policy

Clinical reminders:

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patients
- Use immediate-release opioids when starting
- Start with the lowest effective dosage, and increase dosages slowly
- When opioids are needed for acute pain, prescribe the lowest effective dose and no more than 3 days.
- Follow up and reevaluate the risk of harm, and reduce the dose or taper and discontinue if needed
- Check New York State's prescription drug monitoring program
- Conduct urine drug testing during your therapy

ANTIDEPRESSANT MEDICATION MANAGEMENT

It is important to help members who are diagnosed with depression to adhere to their antidepressant medication plans. When prescribing antidepressants to patients, be sure to explain that it can take 6-8 weeks for them to see improvement in their moods.

It's also important to let patients know the most common side effects of antidepressant medication: nausea, weight gain, lower sex drive, tiredness, trouble sleeping, dry mouth, blurred vision, constipation, dizziness, anxiety, rash, dry mouth, headache, insomnia, sweating, etc. Letting patients know about these possibilities up-front and recommending strategies to minimize any discomfort can encourage them to stay on their medication.

Providers should develop a call reminder process for members to make follow up appointments and to refill their medications. MetroPlus has a Medication Management Program, which allows Medicaid members to refill a 90-day prescription at no cost for this specific type of medication. When possible in the maintenance phase, offer members 90-day refill prescriptions.

Beacon Health Options is the MetroPlus behavioral health vendor. Providers can contact them at **1.888.204.5581** for consultations and referrals when needed.

MEDICATION MONITORING AND ADHERENCE RECOMMENDATIONS

Some of the most common chronic conditions – pain, heart disease, stroke, high blood pressure, pulmonary conditions, mental health disorders -- can be controlled or improved with medication, if taken on a precise, regular schedule. Yet an alarming number of patients fail to take their medicine as prescribed – a practice called "non-adherence" or "non-compliance." This can lead to preventable consequences, including worsening of disease, shorter lives and sudden death. Up to one-half of all patients in the U.S. do not take their medications as prescribed by their doctors.

Poor medication adherence is responsible for avoidable hospital admissions, and 33 to 69 percent of all medication-related hospital admissions in the U.S., at a cost of about $100 billion per year.

STRATEGIES FOR IMPROVING ADHERENCE

PCPs and specialists should always look for signs of poor adherence in their patients. Clinicians can enhance adherence by emphasizing the value of the patient's regimen, making the regimen simple, and customizing the regimen to the patient's lifestyle. If possible, try to decrease the number of medications a patient is taking. Focus on educating the patient on why continuing to take their medications as directed is important.

The finding that adherence declines with time suggests that patients may need some periodic reinforcement of the message that their medication is important and beneficial. For example, after 3 months of treatment a patient is likely to be in remission, but the risk of non-adherence begins to rise. It may pay to contact the patient after 90 days and reinforce the message that continuing with treatment is beneficial to their health.

For more information about medication adherence, visit these resources:

- National Conference of State Legislatures
- The Role of Medication Adherence in the US Healthcare System
- Academy of Managed Care Pharmacy – Improving Medication Adherence: The Role of the Health Care Delivery System and Health Care Providers
- Prescriptions for Healthy America
- Interventional Tools to Improve Medication Adherence: Review of Literature

PRENATAL AND POSTPARTUM VISITS: GUIDELINES AND RECOMMENDATIONS

We encourage our members to take care of themselves during, and after, their pregnancies. If your patient is having a high-risk pregnancy, encourage them to contact our Care Management Program at 212.908.8585 for further assistance.

Approximately 9,000 MetroPlus members will become pregnant every year. We want all our members to receive the important care that they need during this time.

Members should have prenatal appointments once each month for weeks 4 through 28. As the pregnancy progresses, the schedule should be biweekly for weeks 28 through 36, and weekly from week 36 through delivery. Pregnant members with specific health needs may need appointments on a more frequent schedule.

After pregnancy, patients should have a postpartum visit scheduled between 21 and 56 days after the birth. This appointment should cover and denote postpartum care, pelvic exam, or an evaluation combination of weight, BP, breasts (breastfeeding), and abdomen.

In addition to the overall prenatal and postpartum care, providers are encouraged to offer these services to members:

- reducing recurrent preterm birth
- tobacco screening and cessation
- depression screening and follow-up for positive screenings
- providing information about postpartum contraception (Long Acting Reversible Contraception) to promote birth spacing

HOW PROVIDERS CAN IMPACT SMOKING CESSATION

In the most recent Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, only 60.9% of MetroPlus Medicaid members stated that their providers discussed or provided methods and strategies to assist with quitting smoking or using tobacco.

Use the "The 5 A's" to Guide Patient Discussion about Tobacco Use:

- **Ask:** Ask about tobacco use;
- **Advise:** Advise tobacco users to quit;
- **Assess:** Assess readiness to make a quit attempt;
- **Assist:** Assist with the quit attempt;
- **Arrange:** Arrange follow up care.

Tips to Improve Smoking Cessation:

1. Document the conversation in your progress notes; use the CPT codes 99406 (3–10 minutes) or 99407 (>10 minutes) based on the amount of time spent on the topic in your billing so we can support your conversation.
2. Recommend an anti-smoking medication such as nicotine replacement products or oral medications such as bupropion (Wellbutrin) or varenicline (Chantix) if the patient is willing and motivated to quit.
3. Refer the patient to the NYS Smokers Quitline (1.866.NY.QUITS or 1.866.697.8487 or www.nysmokefree.com). They have free counselors and resources to help patients quit

For more information:

- CDC
- National Cancer Institute
- New York State Smokers Quitline
- Treating Tobacco Use and Dependence Guidelines

CHOLESTEROL LOWERING DRUGS

Statins should be recommended for most patients because they are the only cholesterol-lowering drug class that has been directly associated with reducing the risk of a heart attack or stroke. However, non-adherence to statins is a significant issue for the prevention and treatment of cardiovascular disease. Increased awareness of the causes and solutions for overcoming non-adherence, including improvement in physician-patient alliance will enhance the cost-effectiveness of the use of statins and significantly improve patient care and outcomes.

Discuss the risks and benefits of statins with these four groups:

- Adults 40-75 years of age with LDL (bad) cholesterol of 70-189 mg/dL and a 7.5 percent or higher risk for having a heart attack or stroke within 10 years.
- People with a history of a cardiovascular event (heart attack, stroke, stable or unstable angina, peripheral artery disease, transient ischemic attack, or coronary or other arterial revascularization).
- People 21 and older who have a very high level of LDL cholesterol (190 mg/dL or higher).
- People with diabetes and a LDL cholesterol level of 70-189 mg/dL who are 40 to 75 years old.

Assess the patients' risk for a heart attack or stroke based on their cholesterol levels and other risk factors. From there, work with patients to develop a treatment plan that's right for them.

Discuss the possible side effects with patients before starting statins. Order regular liver function tests for patients on statins, and do not recommend statins for patients who are pregnant or who have active or chronic liver disease.

Recommend making lifestyle changes such as quitting smoking, eating right, maintaining a healthy weight and getting the right kind of physical activity to help reduce the risk of heart disease and stroke.

Understand the importance of using translation services, such as language line, and using discharge instructions written in patients' languages to ensure improved compliance.

Emphasize the importance of patients taking and refilling their medications regularly. Prescribe an extended days' supply of 90-day fills whenever possible to support adherence.

Perform comprehensive medication reconciliation to avoid errors of omission, duplication, incorrect doses, or timing and adverse drug-drug or drug to disease interactions.

Patients should be allowed to take part in treatment decisions and, carefully follow the agreed upon treatment plan, and watch for and work with them to resolve any problems that may arise.

For more information:

- American Heart Association
- U.S. Preventive Services Task Force
- How Do We Improve Patient Compliance and Adherence to Long-Term Statin Therapy?

UNDERUTILIZED BEST PRACTICE FOR SMI: LONG-ACTING INJECTABLES

The research is unequivocal: People with serious mental illness (SMI) are at significant risk for relapse and psychiatric hospitalization, primarily related to non-adherence of prescribed oral medications. Treatment research is equally compelling: long-acting injectable antipsychotic (LAI-AP) medications represent a highly effective intervention yet an underutilized treatment for people with SMI.

Beacon, the MetroPlus Behavioral Health vendor, strongly recommends that psychiatric prescribers use a shared decision-making process and systematically offer an LAI-AP as a first-line treatment to most individuals requiring long-term antipsychotic treatment.

The types of antipsychotics are:

First-Generation Antipsychotic (FGA): Targets symptoms of psychosis, delivered orally.

Second-Generation Antipsychotic (SGA): Targets symptoms of psychosis and helps address extrapyramidal side effects of FGAs, delivered orally. Metabolic side effects require monitoring.

Long-Acting Injectable (LAI) Antipsychotic Drugs: Long-acting medication targets psychosis, administered intramuscularly with a one- to four-week effective period. Options include:

- FGA LAI—Haldol Decanoate (Haloperidol), Prolixin Decanoate (Fluphenazine)
- SGA LAI—Risperdal Consta (Risperidone), Invega Sustenna/Trinza (Paliperidone), Zyprexa Relprevv (Olanzapine pamoate), Abilify Maintena (Aripiprazole), Aristada (Aripiprazole lauroxil)

The primary advantages for selecting LAI-APs over oral alternatives include:

- Solves the need for daily administration
- Provides immediate notification of non-adherence with administration transparency and "natural alerts"
- Addresses partial adherence or overt non-adherence
- Reduces risk of unintentional or deliberate overdose
- Lowers relapse rates and rebound symptoms
- Improves individual and physician satisfaction
- Facilitates regular contact with mental health care team

PATIENT-PROVIDER EXPERIENCE

Patient engagement is a growing priority within the MetroPlus physician network and NYC Health + Hospitals. We are dedicated to supporting our providers in delivering the highest quality care and experience.

The CAHPS surveys ask patients about their experiences with their doctors. The following targeted tips can help guide the patient-provider experience:

PATIENT INTERACTION

- Know the patient's medical record details before entering the exam room; patients are surveyed if their doctor knew their medical history
- Ask patients about other doctors and specialists they have seen
- Involve patients in decision making
- Communicate test results and specialist findings to your patient within 24-48 hours and review together at the next follow up appointment
- Use MetroPlus *Gaps in Care* reports to identify additional clinical services needed
- Discuss urinary incontinence and treatment options / physical activity levels with patients over 65 years old
- Discuss aspirin use for cardiovascular health, when appropriate
- Discuss tobacco use and cessation treatment options, when appropriate
- Encourage patients to get a flu vaccination for the flu season

REVIEW PATIENTS' MEDICATIONS

- Review patient medications during office visits and reinforce medication adherence
- Reconcile medications post hospital discharge
- Prescribe an extended days' supply of 90-day fills whenever possible to support adherence

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.
METROPLUS.ORG 1.855.809.4073
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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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Editor: Elizabeth Colombo