MetroPulse provider newsletter

SUMMER 2020

OPIOID PRESCRIPTION GUIDELINES

MetroPlusHealth encourages our providers to follow the *CDC Guideline 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 or end-of-life care).

The CDC guidelines aim to improve communication 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 Clinical Practice Guidelines is also available at the MetroPlusHealth Provider Portal at https://providers.metroplus.org/ Simply log in, select "Forms & Resources," click on "Policy and Procedures" and view the Clinical Practice Guidelines as a PDF.

CLINICAL REMINDERS:

- Check New York State's prescription drug monitoring program
- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss with patients the benefits, risks and availability of nonopioid therapies
- Use immediate-release opioids when starting
- Start with the lowest effective dosage and increase the dosage 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
- Conduct urine drug testing during your therapy
- If you suspect opioid abuse, please contact our **Provider Consultation Line** at **855.588.1574**.

IN-NETWORK LAB USAGE

MetroPlusHealth would like to remind providers that you should refer your MetroPlusHealth 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.

STATIN THERAPY FOR ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ACD) PREVENTION

As part of our ongoing statin initiative, MetroPlusHealth has reached out to members to discuss the importance of taking their statin medication and reporting any side effects to their providers. Members are also reminded about 90-day fills, mail order program and/or PillPack (home delivery) through educational materials.

One of the major barriers to medication adherence for these members is that they are not prescribed the appropriate moderate or high-intensity statin that they need. If your patient is over 21 years old and falls into one of the categories below, consider prescribing them a moderate or high-intensity statin.

Moderate Intensity*	High Intensity
If the patient is diagnosed with clinical atherosclerotic cardiovascular disease, 75 years old or younger and **not** a candidate for a high-intensity statin	If the patient is diagnosed with clinical atherosclerotic cardiovascular disease, 75 years old or younger and a candidate for a high-intensity statin
If the patient is diagnosed with Type 1 or 2 Diabetes, between ages 40 – 75 and has an estimated 10-year atherosclerotic CVD risk of less than 7.5%.	If the patient is diagnosed with Type 1 or 2 Diabetes, between ages 40 – 75 and has an estimated 10-year atherosclerotic CVD risk of 7.5% or higher.
If the patient is between ages 40 – 75 and has an estimated 10-year atherosclerotic CVD risk higher than 7.5%	If the patient is between ages 40 – 75 and has an estimated 10-year atherosclerotic CVD risk higher than 7.5%
If the patient is between ages 40-75 and has an estimated 10-year atherosclerotic CVD risk between 5-7.5% and LDL > 160 mg/dl, family history, hs CRP > 2, CAC>300 or 75%, ABI < .9, or high lifetime risk	If the patient has LDL-C ≥ 190 mg/dl

Visit *https://www.metroplus.org/good4you/coordination-care/Statin-Therapy* for more information.

MODERATE AND HIGH INTENSITY STATINS

Moderate Intensity Statins			High Intensity Statins
Atorvastatin 10–20 mg Rosuvastatin 5–10 mg Simvastatin 20–40 mg	Pravastatin 40–80 mg Lovastatin 40 mg Fluvastatin XL 80 mg	Fluvastatin 40 mg bid Pitivastatin 2–4 mg	Atorvastatin 40-80 mg Rosuvastatin 20-40 mg

**2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults*
A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines

OFFICE WAITING TIME STANDARDS

It's important to remember that excessive office waiting time significantly affects members' overall satisfaction, with both the provider and the health plan. Please follow these standards, which are listed in our MetroPlusHealth *Provider Manual* under "Office Waiting Time Standards":

- Waiting-room times must not exceed one (1) hour for scheduled appointments. Best practice is to see patients within 15 minutes of arrival. If there is an unavoidable delay in seeing the patient they should be told and updated every 10 minutes. Let the patient know they can expect to wait an hour if that is the case. Everybody is busy and waiting an hour with no communication will lead to dissatisfied patients! Consider calling patients before they arrive to let them know you are running behind and reschedule if needed.
- Members who walk in with urgent needs are expected to be seen within one (1) hour.
- Members who walk in with non-urgent "sick" needs are expected to be seen within two hours or must be scheduled for an appointment to be seen within 48 to 72 hours, as clinically indicated.

ANTIDEPRESSANT MEDICATION MANAGEMENT

It is vital that members who are diagnosed with depression receive the treatment and care that they need. Diagnosing the patient and prescribing antidepressant medication is only the first step. Members often need help and guidance to adhere to their antidepressant medication plans.

Some patients may be reluctant to take medication or acknowledge that they need treatment for their depression. Let them know that they're not alone—over 17 million adults in the US have depression, and over 3 million adolescents, according to the National Institute of Mental Health. Informing patients about how common depression is may make them less reluctant to participate in treatment.

There are many reasons a patient may not be adherent to their medication plan. Some may just be forgetful, but often patients don't take their medication for other reasons. If your patient isn't taking their medication correctly, ask why. It's important to be non-judgmental, to get the most truthful answer.

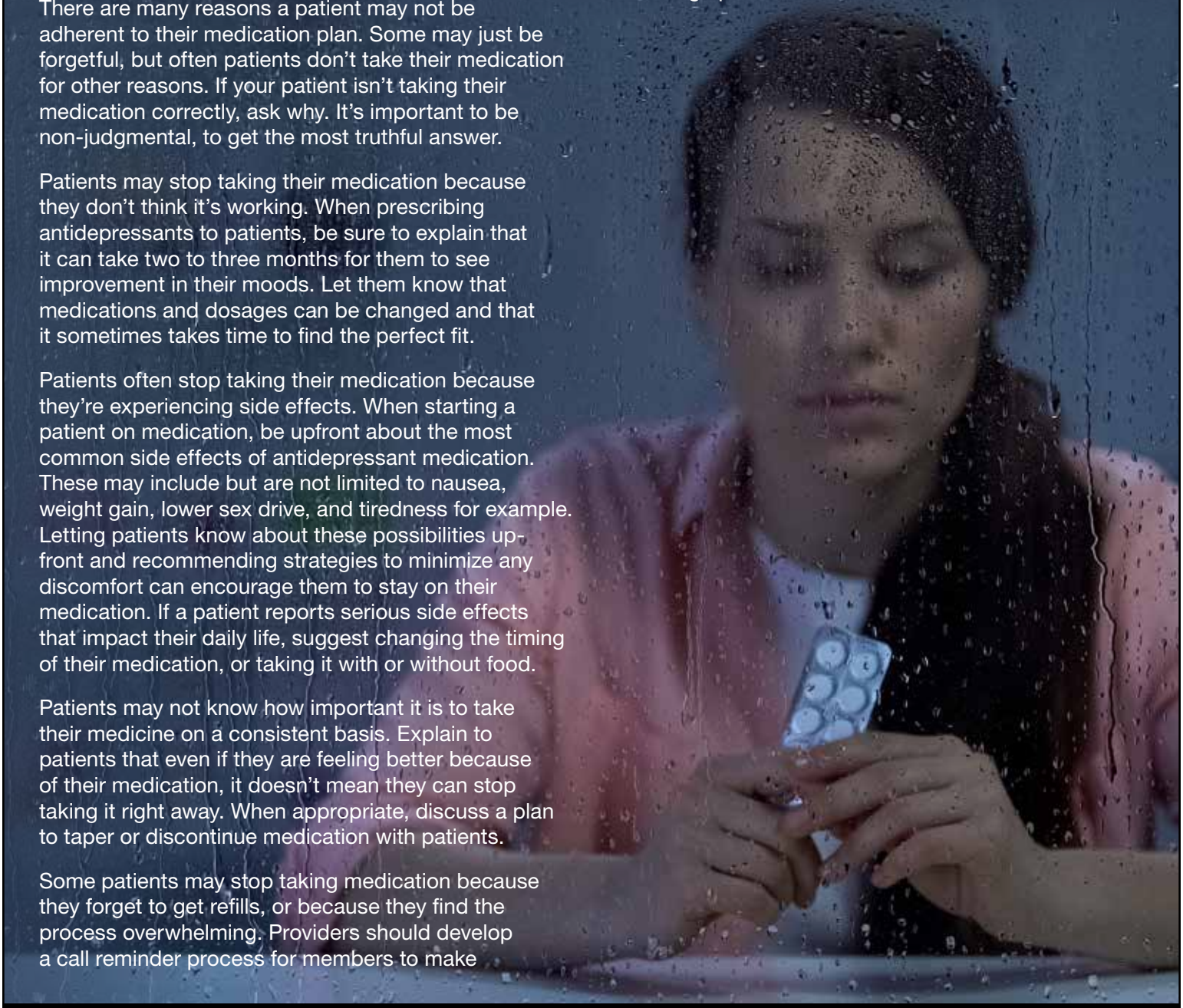
Patients may stop taking their medication because they don't think it's working. When prescribing antidepressants to patients, be sure to explain that it can take two to three months for them to see improvement in their moods. Let them know that medications and dosages can be changed and that it sometimes takes time to find the perfect fit.

Patients often stop taking their medication because they're experiencing side effects. When starting a patient on medication, be upfront about the most common side effects of antidepressant medication. These may include but are not limited to nausea, weight gain, lower sex drive, and tiredness for example. Letting patients know about these possibilities up-front and recommending strategies to minimize any discomfort can encourage them to stay on their medication. If a patient reports serious side effects that impact their daily life, suggest changing the timing of their medication, or taking it with or without food.

Patients may not know how important it is to take their medicine on a consistent basis. Explain to patients that even if they are feeling better because of their medication, it doesn't mean they can stop taking it right away. When appropriate, discuss a plan to taper or discontinue medication with patients.

Some patients may stop taking medication because they forget to get refills, or because they find the process overwhelming. Providers should develop a call reminder process for members to make follow-up appointments and to refill their medications. MetroPlusHealth has a Medication Management Program, which allows Medicaid members to refill a 90-day prescription at no cost for this specific type of medication. In the maintenance phase, offer members 90-day refill prescriptions. Members who take multiple medications can also sign up for our PillPack program, which packages multiple medications together for home delivery or in-store pickup.

Personal support can also make a difference. Patients who trust their provider, and have a good relationship with them, are more likely to stick to a medication regimen. Family members and spouses can also provide a support network to encourage patients to continue treatment.



CREATING A CULTURE OF VACCINATIONS

MetroPlusHealth has partnered with NYC Health + Hospitals to make their pediatric clinics available for babies and children who are due for important vaccines during this COVID crisis. NYC Health + Hospitals has made getting these important visits even safer. There is no sitting in waiting rooms; safe vaccination "lanes" will allow families and children to come in for vaccines and leave quickly. NYC Health + Hospitals will see all MetroPlusHealth babies/children needing vaccines in any of their pediatric clinics, regardless of their child's Primary Care Provider.

NYC Health + Hospitals is now scheduling appointments for vaccinations.
Members can call **1.844.692.4692** and ask for a vaccine visit.

We are committed to protecting children through full coverage and on-time vaccinations. Healthcare professionals are parents' most trusted sources of information about vaccines. Parents may have questions about vaccinations — and that's normal. Even parents who plan to vaccinate their children will still have questions. The CDC has created a list of the most common questions asked by parents. Click here for more information, and answers to questions in terms that are easy for parents to understand.

At every appointment, access the child's vaccination status to see if they are up to date on vaccines. Eligible vaccines should be given in the same visit, including during sick visits, if medically appropriate. There are no known benefits to spacing out vaccines—it just leaves children vulnerable to diseases during the time they are not protected by vaccines. By assessing vaccination status at every visit, we can reduce missed opportunities to vaccinate children and reinforce the message for parents that vaccinations are important.

Everyone has a part to play. Doctors, nurses, and medical assistants give vaccines, but they are not the only people at an office who interact with parents. A culture of vaccination starts at the front desk, and extends into the waiting room, exam room, and check out. Parents' confidence in vaccines is increased when they receive the same information from different people.

Inconsistent messages from staff may confuse patients and create mistrust. To help stay up to date on the latest vaccine recommendations and best practices, the CDC has free vaccine education programs. Visit their website here for more information.

TAKE CARE NEW YORK 2020

Take Care New York 2020 is the City's blueprint for giving everyone the opportunity to live a healthier life. The goal is to improve every community's health, especially among groups with the worst health outcomes.

Take Care New York has examined health and social factors for different areas of the city and has developed a list of top priorities for each community. The Department of Health is working with partners in a variety of sectors to advance these priorities, such as the TCNY 2020 Neighborhood Health Initiative, by bringing community members together and identifying avenues toward better health outcomes.

To learn more about this initiative please click here.

TAKECARE
NEW YORK

FOLLOW-UP CARE AFTER MENTAL HEALTH AND SUBSTANCE ABUSE HOSPITALIZATIONS

Follow up is critical for any member who is hospitalized, especially those who are treated 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 inpatient stay or the Emergency Room, the follow-up should occur within seven days post discharge.

If you are not sure where to refer a member for Behavioral Health services, please contact **Beacon Health Options** at **1.888.204.5581** and select option 2 for Provider Relations. You can also contact Beacon Health Options to connect a member with Case Management Services.

COLORECTAL CANCER: TALK TO YOUR PATIENTS ABOUT THEIR OPTIONS

Most providers recommend that their patients be screened for colorectal cancer (CRC), but it is often difficult to get patients to agree to testing. Patients may not understand the need for screenings or may be afraid that the tests are painful or uncomfortable. It's important that at-risk patients be screened.

Some methods are more effective in getting patients to agree to testing, including explaining the risks of CRC, up to and including death. Offering multiple methods of testing — such as fecal occult blood testing, flexible sigmoidoscopy and colonoscopy — as equally acceptable options also helps. If a patient raises a specific issue or problem, try to work through it with them by explaining more about the test or offering a different option.

For a simple way to speak with patients about their options, the American Cancer Society has developed conversation cards with easy to understand information about different screening methods. Click here to view and download them for use.

The American Cancer Society also provides a simple guide for people who have just been diagnosed with CRC, or their family members. It may help to direct patients to this site if they would like more information after their appointment — it's easy to understand, accurate information that they can access at their own pace. Click here to view their "If You Have Colon or Rectal Cancer" page.

For more information, and to access clinical practice guidelines, visit our provider portal at https://providers.metroplus.org/. Simply log in, select "Forms & Resources," click on "Policy and Procedures," and view the *Clinical Practice Guidelines* as a PDF.

CHILD/TEEN HEALTH PROGRAM

The **Child/Teen Health Program** (CTHP) promotes the provision of early and periodic screening services (well care examinations), with diagnosis and treatment of any health problems identified during the conduct of well care, to Medicaid eligible children under 21 years of age.

CTHP promotes a model of care in which every child has an established, ongoing relationship with a primary health care provider so that health problems can be identified and treated early in their course to improve outcomes and reduce the likelihood of disease, disability, and hospitalization. MetroPlusHealth and our providers are required to provide this care to our qualifying members.

Children and teen members' treatment should include the following, as appropriate by age:

- Comprehensive health and developmental history.
- Assessment of growth and nutritional status.
- Assessment of immunization status and provision of immunizations.
- Screening tests for sensory including vision and hearing tests, nutritional and social problems
- Dental screening services and direct referral to a dentist for children 2 years of age and older.
- Appropriate laboratory testing (including blood lead level assessment appropriate to age and risk).

MetroPlusHealth will monitor provider compliance with the program by using quality indicators (QARR measures such as child immunization (CIS), well-child visits in the first 15 months of life (W15), well-child visits in the third through sixth year of life (W34), annual dental visit (ADV), etc.) as a proxy to ensure providers are providing these services. Data will be used to generate outreach to both members and providers regarding overdue preventive services.

To view the *Bright Futures Recommendations for Preventive Pediatric Health Care* periodicity schedule, click here.

PRENATAL AND POSTPARTUM VISITS:
GUIDELINES AND RECOMMENDATIONS

Approximately 9,000 MetroPlusHealth 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 7 and 84 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.

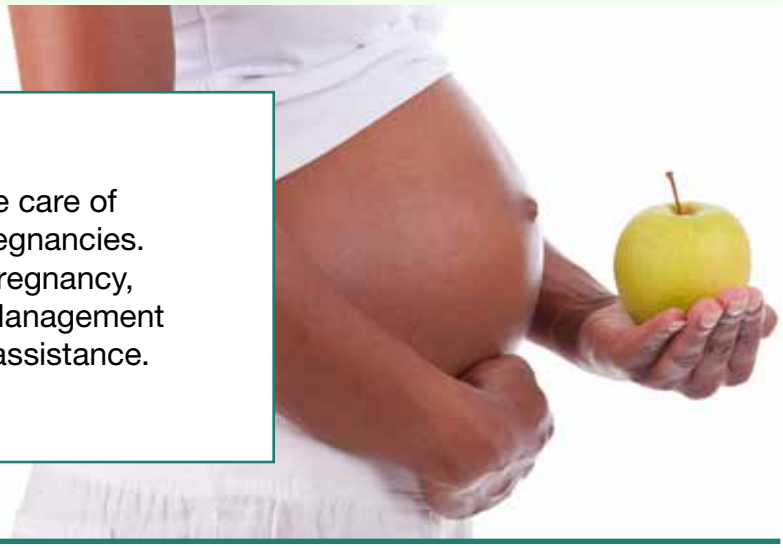
In addition to the overall prenatal and postpartum care, providers are encouraged to offer these services to members:

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

The HEDIS approved codes are:

Prenatal Visits:	**CPT:**	**59400, 59425, 59426**
Postpartum Visit:	**CPT:**	**57170, 58300, 59430**
Depression:	**CPT II:**	**1220F, 3085F, 3351F, 3352F, 3353F, 3354F, 3725F ; HCPCS : G0444, G8431, G8510, G8511, S3005.**
Postpartum Depression:	**ICD-10 CM:**	**F53.0**

Please use these codes when appropriate.



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 **212.908.3639** for further assistance.

DOMESTIC VIOLENCE IS A CRISIS – PROVIDERS CAN MAKE A DIFFERENCE!

Domestic violence and **Intimate Partner Violence** (IPV) have always been present, but recent events have led to a rise in abuse worldwide. Healthcare providers are in a unique position to provide help to those in abusive situations.

Women who talked to their health care provider about experiencing abuse were four times more likely to use domestic violence services in the future. Even brief counseling and harm reduction, along with a referral to community resources can also make a big difference. Abuse does not exist in isolation. Trauma across a patient's lifespan impacts the health of our patients overall, and cycles of abuse can be prevented by working with families.

When addressing abuse with patients, there are some roadblocks that you may encounter. If a patient discloses that they are being abused, it's important to know where they can be referred—either to an on-site resource, or a warm referral, in order to increase the chances of getting the patient assistance when they are open to receiving it. There may be initial discomfort on the part of the provider, but this can be overcome through training, practice, and outside resources. You may become frustrated if a patient doesn't immediately respond to offers of assistance, but it's important to reframe the goal: focus on providing information and support, instead of getting the patient to leave their relationship.

Focusing on IPV may be time-consuming, but simple interventions that are integrated with treatment will save time in the long run.

The following information should be routinely documented in patients' charts:

- Confirmation that the patient was assessed for IPV and reproductive and sexual coercion, or the reason why assessment was not done, and any plans for follow-up actions to ensure that the patient will be screened
- Patient response to screening
- Documentation of resources provided, such as Safety Cards
- Any referrals provided

Although there is no specific CPT code for IPV screening, others can be used:

- **Code V82.89** (Special screening for other conditions)
- Preventive Medicine Service codes 99381-99397 include age-appropriate counseling/anticipatory guidance/risk factor reduction interventions. These codes could be used to record assessment and counseling for IPV.

The following diagnostic codes could also be used:

- **T74.11X** – Adult physical abuse
- **T74.31X** – Adult emotional/psychological abuse
- **T74.21X** – Adult sexual abuse

For more information, visit the CDC's website here or the NYC Domestic Violence Support page here. You can also view New York's Screening Recommendation for Healthcare Professionals and the Centers for Disease Control & Prevention's Intimate Partner Violence Prevention page.

FACTS ABOUT ABUSE

What is Intimate Partner Violence (IPV)?

IPV is when one person in a relationship is using a pattern of methods and tactics to gain and maintain power and control over the other person in a cycle that gets worse over time. Abusers use more than just physical violence — they can use jealousy, social status, mental health, money, and other tactics to be controlling and abusive.

Why do people stay in abusive relationships?

Leaving an abusive relationship is not always the best, safest, or most realistic option for survivors. Often, violence happens in a cycle, and victims weigh the risk of leaving versus the risk of staying. The most dangerous time in an abusive relationship is when the victim is attempting to leave an abusive partner.

Outsiders should move away from asking: "Why hasn't the survivor left?" to asking: "What can I do to support this person so that they can make their own decisions?"

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.

In addition to providing post-hospital TOC care management, we provide onsite care management at some of our facilities. Onsite Care Managers work with facility Care Managers and Discharge Planners to support care coordination and discharge planning activities, with the overall goal of ensuring that members have a safe discharge and smooth transition back into the community.

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

CHOOSING WISELY: LABORATORY TESTS

MetroPlusHealth is committed to helping our providers deliver the best level of service and care to our members. Below are recommendations from the American Society for Clinical Pathology's ***Choosing Wisely*** campaign that identified non-evidence based and over-utilized laboratory tests in the general population. We highly recommend that you review and use this information. For more information, please visit: https://www.choosingwisely.org.

Amylase:

Do not test for amylase in cases of suspected acute pancreatitis. Instead, test for lipase.

Current guidelines and recommendations indicate that lipase should be preferred over total and pancreatic amylase for the initial diagnosis of acute pancreatitis and that the assessment should not be repeated over time to monitor disease prognosis. Repeat testing should be considered only when the patient has signs and symptoms of persisting pancreatic or peripancreatic inflammation, blockage of the pancreatic duct or development of a pseudocyst. Testing both amylase and lipase is ***unnecessary*** because it increases costs while only marginally improving diagnostic efficiency.

Bottom Line: If you suspect, pancreatitis, order a serum lipase.

Folic acid, red blood cell or serum:

Do not order red blood cell or serum folate levels at all.

In adults, consider folate supplementation instead of serum folate testing in patients with macrocytic anemia. With the mandatory fortification of foods (with processed grains) with folic acid incidence of folate deficiency has declined dramatically. In rare cases of folate deficiency, simply treating with folic acid is a more cost-effective approach than blood testing.

Helicobacter pylori antibody:

Do not request serology for H. pylori. Use the stool antigen or breath tests instead.

Serologic evaluation of patients to determine the presence/absence of Helicobacter pylori (H. pylori) infection is no longer considered clinically useful. Alternative noninvasive testing methods (e.g., the urea breath test and stool antigen test) exist for detecting the presence of the bacteria and have demonstrated higher clinical utility, sensitivity, and specificity. Finally, several laboratories have dropped the serological test from their menus, and many insurance providers are no longer reimbursing patients for serologic testing.

Erythrocyte Sedimentation Rate (ESR) in patients with undiagnosed conditions:

Don't order an erythrocyte sedimentation rate (ESR) to look for inflammation in patients with undiagnosed conditions.

Thyroxine, total; Thyroxine, free; Triiodothyronine T3 (TT-3) in the initial evaluation of a patient with suspected, non-neoplastic thyroid disease, and routine screening Thyroid Stimulating Hormone testing:

Don't order a total or free T3 level when assessing levothyroxine (T4) dose in hypothyroid patients or when you are trying to determine if someone is hypothyroid or hyperthyroid. Don't order TSH for routine screening.

T4 is converted into T3 at the cellular level in virtually all organs. Intracellular T3 levels regulate pituitary secretion and blood levels of TSH, as well as the effects of thyroid hormone in multiple organs. However, T3 levels in blood are not reliable indicators of intracellular T3 concentration. Compared to patients with intact thyroid glands, patients taking T4 may have higher blood T4 and lower blood T3 levels. Therefore, in most patients all you need is a TSH to determine the correct dosing of levothyroxine.

Bottom Line: Order a TSH to monitor and adjust levothyroxine dosing. Don't order TSH for routine screening; only for someone in whom you clinically suspect hypothyroidism or hyperthyroidism.

Vitamin D, including fractions:

Don't routinely measure 1,25-dihydroxyvitamin D unless the patient has hypercalcemia or decreased kidney function.

Many practitioners become confused when ordering a vitamin D test. Because 1,25-dihydroxyvitamin D is the active form of vitamin D, many practitioners think that measuring 1,25-dihydroxyvitamin D is an accurate means to estimate vitamin D stores and test for vitamin D deficiency, which is incorrect.

Prealbumin:

Do not use prealbumin test to screen for or diagnose malnutrition.

Studies have shown that as a nutritional marker, prealbumin is not specific enough to show changes in nutritional status; additionally, it is not sensitive to detection of malnutrition at an early stage. Furthermore, improvement in nutritional intake have not resulted in notable change in prealbumin. Instead, consider a multidisciplinary approach that includes consulting with dieticians to better understand the patient's medical history and to ensure the selected metrics are used appropriately for diagnosis and documentation. Click here for more information.

Ammonia:

Do not use an ammonia test, in patients with chronic liver disease, to measure blood ammonia level because normal levels do not rule out hepatic encephalopathy.

Click here for more information.

ACCESS AND AVAILABILITY STANDARDS

NYS DOH Medicaid regulatory requirements determine MetroPlus' appointment guidelines. Members must secure appointments within the following time guidelines to be compliance with NYS DOH requirements:

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

Medicaid Managed Care PCPs are required to schedule appointments in accordance with the aforementioned appointment and availability standards. Providers ***must not*** require a new patient to complete prerequisites to schedule an appointment, such as a copy of their medical record, a health screening questionnaire, and/or an immunization record. The provider may request additional information from a new member, if the appointment is scheduled at the time of the telephonic request.

MetroPlusHealth

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CHANGES TO YOUR DEMOGRAPHIC INFORMATION

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

METROPLUSHEALTH COMPLIANCE HOTLINE

MetroPlusHealth has its own Compliance Hotline, **1.888.245.7247**. Call this line to report suspected fraud or abuse, possibly illegal or unethical activities, or any questionable activity. You may choose to give your name, or you may report anonymously.

Editor: Elizabeth Colombo