MetroPulse provider newsletter

WINTER 2019-2020

WHAT TO EXPECT:

- **New! Online Claims Entry**
- **New! Online Authorization Entry**
- **New! P4P Reports, Patient Gaps in Care, Utilization Reports, and much more**
- **Check Eligibility, Claims, Payment and Authorization Status**

OUR PROVIDER RELATIONS TEAM WILL BE REACHING OUT TO YOU TO OFFER TRAINING SHORTLY!

NYC H+H LAUNCHES EPICCARE LINK

H+H has launched EpicCare Link, a secure web tool that provides real-time access to patient information. EpicCare Link can be used to access patient's clinical data (including charts, recent events, and upcoming appointments) and to quickly refer patients.

Since EpicCare Link is a web portal, there's no need to download any programs – just log in on the website at epiccarelink.nychhc.org. The portal eliminates the need to send phone or fax requests for referrals to H+H, making the process quicker and more streamlined. You can also be notified about your patients' care, such as hospital admissions and discharges; lab, imaging, test results; and more.

To sign up, visit epiccarelink.nychhc.org and click ***Request New Account***.

HELP MEMBERS QUIT VAPING

Vapes and electronic cigarettes have skyrocketed in popularity—in part, due to their false reputation as a "good for you" alternative to cigarettes. This trendy habit is especially popular with teens and young adults but has increased among all age groups.

The recent illnesses and deaths caused by vaping may have become the motivation for some members to quit, but they may not know where to turn. MetroPlus can help!

MetroPlus members who are trying to quit vaping are eligible for all the same smoking cessation programs as those trying to quit traditional cigarettes. This includes (depending on a member's plan) counseling, medication, and assistance utilizing other resources in the community. Let members who vape know that they have access to help through their plan.

Encourage all members who vape or smoke to contact MetroPlus Member Services at the number and hours listed on their ID card, the NY Smokers' Quitline (866-NY-QUITS) or 311.

DRUG-RESISTANT INFECTION ON THE RISE

A serious public health risk is challenging healthcare professionals across the country.

Candida auris is fungus that presents a serious global health threat. ***C. auris*** causes serious infections, and more than 1 in 3 patients with invasive ***C. auris*** die. ***C. auris*** is especially prevalent in hospital and nursing home patients, who have other complicating medical conditions.

C. auris is multidrug resistant, difficult to identify in standard labs, and spreads quickly in healthcare facilities. For these reasons, it is vital that it is identified quickly, so facility staff can take precautions to stop it from spreading. It is important to emphasize adherence to hand hygiene, cleaning and disinfecting the patient care environment, and screening those who have been in contact with ***C. auris*** patients. ***C. auris*** can be spread even by those who are asymptomatic.

The CDC has Recommendations for Identification, Treatment, and Infection Prevention and Control available on their website at https://www.cdc.gov/fungal/candida-auris/.

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 MetroPlus *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 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 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.
- Members who walk in with urgent needs are expected to be seen within one (1) hour.

PRENATAL IMMUNIZATIONS

Due to changes to the immune system, heart, and lungs during pregnancy, pregnant women are at a higher risk for severe illnesses and complications from the flu, including premature labor and preterm births. The flu vaccine is recommended in any trimester for women who are pregnant or plan to become pregnant during flu season. Pregnant patients also receive a tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine during each pregnancy, as early in the 27–36-weeks-of-gestation window as possible.

Providers seeing pregnant patients should follow recommendations from the American College of Obstetricians and Gynecologists:

- Obstetrician/gynecologists and other obstetric care providers should routinely assess their pregnant patients' vaccination status.
- Obstetrician/gynecologists and other obstetric care providers should recommend and, when possible, administer needed vaccines to their pregnant patients.
- Women who are or will be pregnant during influenza season should receive an annual influenza vaccine.
- All pregnant women should receive a tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine during each pregnancy, as early in the 27–36-weeks-of-gestation window as possible.
- Other vaccines may be recommended during pregnancy depending on the patient's age, prior immunizations, comorbidities, or disease risk factors.

For more information, visit the American College of Obstetricians and Gynecologists website.

PREVENTIVE VISIT AND YEARLY WELLNESS EXAMS FOR MEDICARE MEMBERS

Medicare's annual enrollment concluded in December, and MetroPlus is happy to be welcoming new members for the 2020 plan year. Providers should encourage new and existing members to receive the medical exams they are eligible for.

A "Welcome to Medicare" preventive visit: Members can get this introductory visit only within the first 12 months they become eligible for Part B. This visit includes a review of medical and social history related to health education and counseling about preventive services, including these:

- Developing a medical and family history, and a list of current providers and prescriptions
- Height, weight, and blood pressure measurements
- A calculation of body mass index
- A review of potential risk for depression and level of safety
- A written plan letting the patient know which screenings, shots, and other preventive services they need.

Yearly "Wellness" visits: The main purpose of this visit is to develop or update a personalized prevention help plan. This visit is covered once every 12 months (11 full months must have passed since the last visit). This plan is designed to help prevent disease and disability based on current health and risk factors. Providers should ask patients to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help patients and their providers develop a personalized prevention plan to help them stay healthy and get the most out of the visit. It can also include:

- A review of medical and family history
- Developing or updating a list of current providers and prescriptions
- Height, weight, blood pressure, and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options for the patient
- A screening schedule (like a checklist) for appropriate preventive services.

PROVIDER EDUCATION MESSAGE FROM CMS:
MOST HICN CLAIMS REJECT – REGARDLESS OF DATE SERVICE

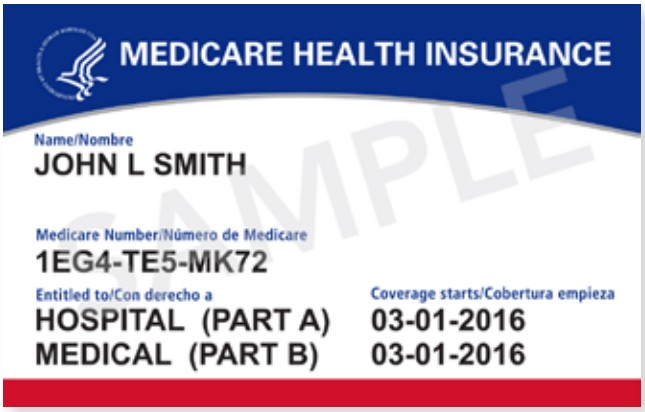
Use **Medicare Beneficiary Identifiers** (MBIs) now to avoid claim and eligibility transaction rejects.

Starting January 1, 2020, regardless of the date of service on the Medicare transaction, most Social Security Number-based Health Insurance Claim Number (HICN) Medicare transactions will reject, with a few exceptions.

If you do not use MBIs on claims after January 1, you will get:

- **Electronic claims reject codes:** Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber).
- **Paper claims notices:** Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier."

Thank you for transitioning to MBIs during the 21 month transition period, protecting your patients from identity theft.



- You are currently submitting 87% of claims with MBIs.
- If your patient doesn't have their new card, give them the **Get Your New Medicare Card flyer** in English or Spanish.
- Get MBIs through the MAC portals (PDF) now and after the transition period. You can also find the MBI on the remittance advice.

See the MLN Matters Article for more information on getting and using MBIs.

ASTHMA MANAGEMENT

Symptoms of asthma can be controlled with the correct treatment plan in place—but some patients may not be taking their prescribed medication correctly. Here are some key steps you can take to encourage a partnership with patients and their families:

- Perform medication reconciliation to avoid duplicate orders and be aware of your members' prescription status. It is important to make sure that members are getting and using the medication they need.
- Educate patients on the importance of having both long acting and short acting medications refilled. We find many members who incorrectly utilize only short acting medications.
- For children with asthma, work with parents to complete any forms the child's school requires to allow children to take their asthma medication to school.
- If your hospital or clinic uses Epic, encourage members to sign up and utilize it as a tool for tracking your patients' treatment and as a way to communicate.
- Talk to your patients about issues that impact their adherence to their treatment plans. Difficulties they have with their inhalers, confusion with their medication regimen, or side effects from the medicine may make them less likely to take the medication they need. Other issues may affect their ability to take their medication, such as access to medication or pharmacies, or psychosocial factors. Finding out what issue your patient has and suggesting ways to combat it can increase adherence.
- Use a full asthma assessment such as the Stepwise Approach. The Stepwise Approach allows the medication a patient takes to be tailored to their needs, increasing or decreasing dosages to achieve a balance between reducing the impairment caused by asthma and reducing the risk of too much medication.

AVOIDANCE OF ANTIBIOTICS

Antibiotic resistance is rising to dangerously high levels, caused in part by overprescribing antibiotics. It is crucial that providers prescribe antibiotics only when necessary for a patient's condition.

During the winter season, patients often specifically request antibiotics for things like cold, flu, or other illnesses that cannot be treated by antibiotics. Providers should explain to patients that these treatments would be ineffective and expose them to unnecessary side effects.

You can also utilize **"Watchful Waiting"** and **"Delayed Prescribing"** in situations where a patient is unlikely to need antibiotics:

- **Watchful Waiting** instructs patients to rest, drink fluids, and try other methods to recover from their illness. If they are still ill after a set period, instruct them to call your office for a prescription or a second visit.
- **Delayed Prescribing** instructs patients to wait before filling their antibiotic prescription, in order to see if they recover on their own. Delayed Prescribing is helpful for patients who cannot make multiple appointments.

Unfortunately, quality monitoring of our providers still reveals the unnecessary prescribing of antibiotics. Provider offices are routinely monitored for the appropriate testing of children with pharyngitis. Good care calls for performing a rapid strep test or throat culture before prescribing an antibiotic. For more information, including handouts for patients explaining about antibiotics, antibiotic resistance, watchful waiting and delayed prescribing, visit https://www.cdc.gov/antibiotic-use/.

CARE FOR OLDER ADULTS

As patients age, they feel the side effects of aging — pain increases, and physical function and cognitive ability often decrease. Assessing functional status and pain, conducting medication reviews, and advance care planning can ensure that older adults receive comprehensive care that prevents further health status decline in a manner respectful of their wishes.

- **Functional status assessment:** Screening is effective in identifying functional decline. Physical ability is an important indicator for health and well-being in old age, as it decreases with age. Physical functional decline is often an initial symptom of illness in older people, and early detection of functional decline allows earlier treatment or intervention.
- **Pain assessment:** Pain is also a frequent symptom of illness and disease in older ambulatory and hospitalized patients. Elderly individuals are more likely to have arthritis, bone and joint disorders, cancer and other chronic disorders associated with pain. Additionally, the consequences of under-treating pain can have a negative effect on the health and quality of life in the elderly, with the onset of depression, anxiety, reduced socialization, sleep disturbances and impaired mobility.
- **Advance care planning:** As people age, consideration should be given to their treatment wishes if they lose the ability to manage their care. A large discrepancy exists between the wishes of dying patients and their actual end-of-life care. Advance directives are widely recommended as a strategy to improve compliance with patient wishes at the end of life and thereby ensure appropriate use of healthcare resources. There is expert consensus on the need for advance directives, as well as a regulatory mandate, but only 15 to 25 percent of adults complete them, usually after a serious illness or hospitalization. It has been found that most adults would prefer to discuss advance directives while they are well, preferably with a doctor who has known them over time. Most say they look to their doctors to initiate the discussion.
- **Medication review:** Most older adults take medications to address at least three or more chronic conditions. Many have multiple prescribing physicians and use more than one pharmacy, necessitating regular review of medications. A medication list should include prescriptions and over-the-counter (OTC) medications (including herbals, supplements); dose, frequency, and reason for taking the medication. Poor medication management can lead to adverse drug events, overdoses, and underutilization of drugs, all of which can result in increased hospitalizations.

MetroPlus has a ***Care for Older Adults Assessment Form*** in English and Spanish located on our website that can help make visits with your patients more effective.

MEDICARE HOS:
IMPROVING OR MAINTAINING PHYSICAL AND MENTAL HEALTH

The Medicare Health Outcomes Survey (HOS) collects patient-reported information about health outcomes. The HOS is a longitudinal survey administered each spring to a random cohort of Medicare members, and the same members are resurveyed after two years to see if their health status is better, the same, or worse.

Improving or maintaining physical and mental health are a key measurement of the HOS, and to ensure good results, patients' care should be focused on their personal needs. For example, discuss behavioral health treatment options with patients experiencing behavioral health symptoms and encourage patients to start or increase their physical activity with exercise suitable for each patient. Review fall risks with patients (see the ***Fall Prevention and Risk Assessment*** article on below for more), and discuss sensitive topics including urinary incontinence with your patient and present solutions they can try.

The results of this survey are used to identify areas where improvement is needed and monitor plan performance. For more information, visit www.hosonline.org.

FALL PREVENTION AND RISK ASSESSMENT

STEADI Stopping Elderly Accidents, Deaths & Injuries

As patients age, their risk of falls and the associated injuries associated grows. More than one out of four people 65 and older fall each year, and over 3 million are treated in emergency departments annually for fall injuries.

The CDC's STEADI (Stopping Elderly Accidents, Deaths, & Injuries) Initiative has developed strategies and resources to help providers screen patients, assess their risk of falling, and intervene to reduce their risks.

The STEADI Initiative recommends asking all patients over age 65 three questions:

1. Have you fallen in the past year?
2. Do you feel unsteady when standing or walking?
3. Do you worry about falling?

If your patient answers "yes" to any of these key screening questions, they are considered at increased risk of falling. Further assessment is recommended, such as:

- **Functional assessment** – Assessment of a patient's level of functioning, accomplished by asking standardized questions about difficulties with performing activities of daily living (also known as basic activities, such as walking, feeding, and bathing) and instrumental activities of daily living (such as managing household tasks, finances, and medications).
- **Environmental assessment** – Conducted by a trained health professional, this identifies hazardous conditions within the home, such as obstacles in pathways or on stairs, unsupportive or ill-fitting footwear, unsuitable assistive devices, inadequate lighting, and slippery surfaces.
- **Medication review** – MetroPlus Medicare members have access to a Medication Therapy Management program, which includes a Comprehensive Medication Review and a Targeted Medication Review. Click here for more information.

FOLLOW-UP AFTER INPATIENT OR EMERGENCY ROOM DISCHARGE

Follow up is ***critical*** for every member who is hospitalized as an inpatient or seen in the emergency room. Members who are seen for follow up care are more likely to have better health outcomes.

Whether a patient is discharged from an emergency room or an inpatient stay, the follow up should occur within seven days. If your patient needs help getting a referral for medical services, call MetroPlus at 1**.800.303.9626**, 24/7.

If a member needs a referral for Behavioral Health services please contact our Behavioral Health vendor, Beacon Health Options at **1.888.204.5581**, 24/7.

CHOOSING WISELY: LABORATORY TESTS

MetroPlus 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 overutilized 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.

USE OF IMAGING FOR LOW BACK PAIN

Low back pain is one of the most common reasons adults visit the doctor. Patients may have certain expectations of what tests they would like performed, but these are not always the correct method of treatment.

Imaging should ***not*** be performed for low back pain within the first six weeks of symptoms, as most patients with low back pain will recover within a few weeks. Imaging of the lower spine before six weeks does not improve outcomes but does increase costs.

Exceptions should be made for patients exhibiting red flags in their medical history, such as neurological symptoms or other serious underlying conditions.

The American Academy of Family Physicians has come up with some tips for talking with patients about this:

Issues:	Suggested Talking Points:
Provide Clear Recommendations: Most patients want information about their health, illness and decision options.	• "The good news is that based on your history and your normal physical examination I do not think that you need an x-ray." • "I would not recommend an x-ray at this point given these findings and the fact that except for having pain in the back from muscle spasm your examination is normal.
Elicit Patient Beliefs and Questions: Understanding patients' treatment goals and perspectives about their health during the visit will help improve patient satisfaction and can shorten visits.	• "You look concerned do have any questions for me?" • "Is there anything you are concerned about?" • "What do you think is going on and what are you worried about?"
Provide Empathy, Partnership, and Legitimation: Patients are more satisfied and are more likely to adhere to recommendations if they feel understood, supported, and a sense of partnership with their physicians. Make it clear that you are on the patient's side.	• "I certainly understand that you want to get better." • "I want to reassure you that your symptoms are very different from those of your brother or someone with a herniated disc."
Confirm Agreement and Overcome Barriers: Finding common ground and understanding patient perspective and barriers will help reach agreement and provide patient satisfaction and hopefully improve patient health outcomes	• "I want to be sure you are comfortable with this plan. I do not think you need a plain x-ray as they show us the boney problem which is unlikely to be the problem. A CT scan is not particularly helpful and exposes you to a lot more radiation. An MRI is the gold standard, but the problem is that even in healthy patients we see abnormal discs, so we are never sure that the finding on the MRI are related to your symptoms." • "There are things we can do to help your symptoms to help you feel better. Let's try this treatment and I will see you back in 6 weeks. If you develop any new symptoms like weakness in your legs, numbness or pain down the leg you should call me. However, I expect like most people with low back pain you will start to feel better with the treatment."

Visit their website for more information.

SCREENINGS

IMPORTANCE OF DEVELOPMENTAL SCREENINGS

Early identification of developmental delays in children can help the child and family receive needed intervention services and support. Developmental screenings are required for children enrolled in in Medicaid and CHP under Early and Periodic Screenings, Diagnostic and Treatment (EPSDT).

Developmental screenings using formal, validated tools should be conducted at well-child visits at 9, 18 and 24 (or 30) months to ensure timely identification of children at risk for developmental, behavioral, and social delays. Developmental surveillance should be performed at all other well-child visits. The American Academy of Pediatrics (AAP) also recommends screening all children for autism spectrum disorder at 18 and 24 months. The AAP has screening tools available on their website.

Depending on the results of the screening tests, further evaluation may be needed. Screening tools cannot provide conclusive evidence of developmental delays or final diagnoses. If a screening has positive results, a thorough assessment from a trained provider should follow. Providers should make a referral to Early Intervention services when they suspect that a child has developmental disorder. Do not wait for a diagnostic developmental evaluation to be performed in order to avoid unnecessary delays. To refer a patient for early intervention, click here.

Providers should use the CPT code **96110** to report the use of a standardized developmental tool. The standardized developmental tool must address motor, cognitive, language and social emotional skills. To differentiate autism screenings at 18 and 24 months, providers should add the **CG** modifier to CPT code 96110 for claims for autism screenings.

CAHPS SURVEY

Every year, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey gathers feedback from consumers to better understand their overall health care experience. The survey results are then used by health plans, primary care providers and hospital leadership to improve health outcomes and member satisfaction/experience.

Why is the CAHPS survey important?

1. It serves as a guide to promote a positive member experience which will retain loyal members, improve finances, and reduce costs / disenrollment.
2. It aids in building a service culture with the goal of encouraging staff to have respect and compassion for members.
3. It motivates all entities to deliver good customer service and improve the member experience. Scores are often tied to Provider and Health Plan Pay for Performance Programs.

MetroPlus recommends these tips to improve member experience:

- **Personal Connection:** When a member arrives, make sure they feel welcome. A smile or greeting when they enter can set a positive tone for the rest of the visit.
- **Easy Access:** To help our members get the care they need, consider extending office hours and providing multiple services during a single visit.
- **Watch the Wait Times:** If there's a long wait, apologize and explain the reason for the delay. A waiting member should be approached every 10 minutes and provided with options that may include rescheduling.
- **Fight the Flu:** Ask members if they've gotten their flu vaccine. If they haven't, encourage them to do so as soon as possible.

HEDIS DATA COLLECTION

MetroPlus Health Plan collects data from providers that support quality measures included in HEDIS/QARR reporting, MetroPlus Pay-for-Performance (P4P) Program and Value-Based Payment (VBP) contracts.

To ensure your scores are accurate, MetroPlus collects the following information during these timeframes:

Data Collected	Timeline	Purpose and Request
Claims Data	**January 2019 – February 2020**	Claims should be submitted immediately following the rendering of services and applied to your quality measure performance if received before February of the reporting year and appropriately coded. Please review the HEDIS/QARR Reference Guide and Coding Sheet to ensure the services provided are captured by utilizing the correct codes. Go to https://www.metroplus.org/Provider/Tools
Encounter Files	**January 2019 – February 2020**	Encounter files are accepted for all measures **throughout the measurement year and into the beginning of the reporting year** to account for claims run out. While you may submit encounter files for any measure, we strongly recommend prioritizing ***non-hybrid*** measures when submitting encounters. You may email us at QMOPHEDIS4@metroplus.org if you would like information on how to submit encounter files.
Supplemental Files	**January 2019 – February 2020**	Supplemental files that are electronically extracted from your Electronic Medical Record (EMR) or billing system are accepted and recommended throughout the measurement year and into the beginning of the reporting year. You may email us at QMOPHEDIS4@metroplus.org if you would like information on how to submit supplemental files.
Supplemental Record Review	**January 2019 – February 2020**	MetroPlus collects medical record documentation for select measures to supplement claims and encounter data. The format can be PDF or image and may include the entire medical record or the relevant portion of it. MetroPlus will mail supplemental medical record requests to providers in **October 2019.**
Hybrid Record Review	**January 2020 – May 2020**	Hybrid measures are reported using a **sample** of about **411** members across the Plan's entire provider network for each product line. Once the sample selection is drawn for each hybrid measure, medical record requests for documentation of missing services will be mailed to providers in **February 2020.** Only medical records are accepted when fulfilling hybrid gap in care requests. We have found that submitting encounter and/or supplemental data throughout the measurement year can reduce the need for hybrid medical record review.

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

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.

MetroPlus Health Plan
160 Water Street, 3rd Floor
New York, NY 10038
1.855.809.4073
metroplus.org

CHANGES TO YOUR DEMOGRAPHIC INFORMATION

Notify MetroPlus 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 MetroPlus at **212.908.8885**, or by calling **1.800.303.9626**.

METROPLUS COMPLIANCE HOTLINE

MetroPlus 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