# TheSource

Summer 2018



healthfirst®
Health Insurance for New Yorkers

## IN THIS ISSUE



## CONTACTS

**Provider Services**
1-888-801-1660
Monday to Friday, 8:30am–5:30pm

**Utilization Management & Behavioral Health Unit**
1-888-394-4327
Monday to Friday, 8am–5:30pm

**Fraud, Waste, & Abuse Anonymous Hotline**
1-877-879-9137
Monday to Friday, 9am–5pm

**Member Services: Medicaid and Child Health Plus (CHP)**
1-866-463-6743
Monday to Friday, 8am–6pm

**Member Services: Medicare Plans**
1-888-260-1010
7 days a week, 8am–8pm

**Member Services: Essential Plans and Leaf Plans**
1-888-250-2220
Monday to Friday, 8am–8pm

**Member Services: Personal Wellness Plan**
1-855-659-5971
7 days a week, 24 hours a day

**Member Services: Senior Health Partners**
1-800-633-9717
Monday to Friday, 8am–8pm
Saturday, 10am–6:40pm

**Member Services: Healthfirst Total EPO Plans and Healthfirst Pro EPO and Pro Plus EPO Plans**
1-855-789-3668
Monday to Friday, 8am–6pm

**FIDA Participant Services**
1-855-675-7630
Monday to Sunday, 8am–8pm

**Member Services: TTY for Medicaid, Child Health Plus (CHP), Medicare, Leaf Plans, Essential Plans, Personal Wellness Plan, Senior Health Partners**
English: 1-888-542-3821
Spanish: 1-888-867-4132

**Member Services: TTY for FIDA Participant Services**
English: 711

**Member Services: TTY for Healthfirst Total EPO Plans and Healthfirst Pro EPO and Pro Plus EPO Plans**
English: 1-855-779-1033
Spanish: 1-855-779-1034


**Produced by:**
Healthfirst Marketing and Brand & Creative Strategy


**www.healthfirst.org/providers**

From the desk of the

# Chief Clinical Officer

Dear Valued Provider:

Welcome to the summer edition of *The Source*, Healthfirst's provider news magazine and your source for information that helps your practice navigate claims and compliance issues, stay updated on key initiatives and trends, and care for our members.

For the past 25 years, Healthfirst has partnered with providers to improve the quality of care delivered to members. One important measure of our combined progress with Medicare members is the Health Outcomes Survey. I encourage you to turn to page 10 to learn about three key conversations you should have with your Medicare patients about their health.

This issue of *The Source* also includes educational articles on cancer screening for breast, cervical, and colorectal cancers, HIV/AIDS and STD reminders, and mental health and substance abuse. These are important issues faced by the populations we serve.

As always, I encourage you and your team to review this issue closely, as the information here will help you help our members get appropriate care, and help your practice as they work with Healthfirst.

Thank you for the care you provide to our members, and for partnering with Healthfirst to improve the health and well-being of our communities.

Until next time,

Jay Schechtman, M.D., M.B.A.
Chief Clinical Officer

Let us know what you think of ***The Source***. Send us an email at **source@healthfirst.org**.

# Claims Payment:
# Introducing Virtual Cards®

**Healthfirst is excited to offer a new electronic claim payment option called Virtual Credit Card (VCC).** Healthfirst provides electronic claim payments using Virtual Credit Cards (VCC), issued through the MasterCard network, in lieu of paper checks. This enhancement, already used extensively across the industry, is a faster, more efficient, and safer method of payment.

*This change applies only to providers who received paper checks.*

**What is a VCard?**
A VCard is an electronic replacement for checks, which currently require printing and mailing. A VCard lets your office receive payments electronically via the MasterCard network.

No paperwork is required to receive a claim payment via a MasterCard.

**What are the benefits of VCards?**
Providers accepting VCards enjoy the following benefits:

- **Faster payments.** VCards are delivered via fax, so you will receive payments much quicker than you would with mailed checks.
- **Easier reconciliation.** All past Explanation of Payments (EOP) and payment details are stored for you on the Healthfirst portal site for easy access and reconciliation.
- **No bank deposits.** Electronic delivery will deposit your funds directly into your merchant account.
- **Protection against fraud.** VCards eliminate the risk of fraud. VPay, Healthfirst's partner, guarantees the delivery of funds to your account, regardless of any attempt to process a VCard fraudulently. No more stolen, lost, or whitewashed checks.

*Continued on pg. 6*

## Claims Payment: Introducing Virtual Cards®

*Continued from pg. 5*

**How do I get reimbursed via VCards?**
VCards are delivered primarily by fax, so you receive payments much quicker than you would with checks.

**What does a VCard look like?**
You will receive a fax with the virtual card information and directions on how you can process the payment.

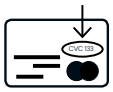
# EXPEDITED PAYMENT— Claim #: 17D48F014624

**4 easy steps to process the payment**

**STEP 1:** Type in the 16-digit number


**STEP 2:** Type in dollar amount


**STEP 3:** Enter CVC



**STEP 4:** If requested, enter this address or zip: 111 W. Spring Valley Rd., Richardson, TX 75081


**No PIN required.**

Problems? Email the VPay Support Center at **support@vpayusa.com** or call 888-888-1234. Please have your VP Trans ID (located above) available.


| | |
|---|---|
| Client Ref ID: | 1234567890123456789 |
| VP Trans ID: | 2114745553<br>TPA0001001 |
| Date: | 11/1/17 |
| Amount: | $60.22 |

**INSURANCE PROFESSIONALS** is expediting this payment to you for services rendered. This Mastercard payment can be processed through your merchant terminal as illustrated in Steps 1-4.

If you elect to accept payment by this virtual card, processing fees will be assessed at the rate outlined in your merchant agreement with your acquiring bank. If your organization prefers a different form of payment, please email **support@vpayusa.com or call 888-888-1234** to discuss your payment preference.

If you have questions regarding your claim or benefit plan, please contact Insurance Professionals at 555-123-4444 or at claims@insuranceprofessionals.com.

**IMPORTANT HIPAA NOTICE**: The information contained in this VPay communication contains data considered Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is transmitted subject to HIPAA privacy rules and subsequent penalties for improper use. If the information contained in this communication does not pertain to a current patient at this facility, please 1) notify VPay immediately at 877-399-5917 and provide the VP Trans ID shown and 2) destroy this communication and all attached information.

## Did you know? VCard is Better.

**FAST**
Pays in real-time, 10 days faster than checks. Improves revenue-flow.

**SIMPLE**
VCard and remittance advice delivered together.

**How do I process a VCard payment?**
VCards can be processed through your merchant terminal as a standard credit card transaction. You will receive funds promptly and in the same manner as other credit card transactions processed through your merchant terminal.

You must follow the four easy steps below to process the payment:

- Type in the 16-digit number
- Type in dollar amount
- Enter CVC
- If requested, enter this address or zip:
  111 W. Spring Valley Rd., Richardson, TX 75081

**How many days do I have to pull the money once I receive the VCard fax?**
You have 45 days to process the VCard payment.

**I don't have a merchant terminal to process credit card transactions. What can I do?**
You can contact VPay, our Virtual Credit Card provider, at **1-844-224-6558**. They will have their Merchant Services team contact you. They can provide a terminal at no cost and at a lower merchant fee than any other provider.

**Is VCard a secure process?**
Yes. VPay, our Virtual Credit Card provider, has a rigid infrastructure to provide extensive security and control over all data and processes. VPay is PCI certified, has achieved SSAE16 SOC 2 certification, and is HIPAA compliant. In addition, VPay has multiple fraud-prevention processes built in and guarantees delivery of all funds to the intended payee.

**Does a VCard cost anything?**
You pay nothing to Healthfirst to use a VCard. However, just as it would be when any other ordinary credit card is used, a processing fee may be assessed by your credit card processing company.

**What other option do I have to receive payment of claims I submit to Healthfirst?**
You may choose Electronic Funds Tranfer (EFT)/Electronic Remittance Advice (ERA) to receive payment that is wired directly into your checking account.

**How can I sign up for EFT/ERA?**
You may obtain the EFT form from the following sources only:

- Healthfirst Provider Secure Services website, accessible at **www.healthfirst.org/providers**. You must sign in with your username and password. If you do not currently have an account, you must create one to access the form
- Provider Services, **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm

# Everything You Need to Know About Online Authorization Requests

## Our Online Authorization Request tool is intuitive and easy to navigate.

This online feature enables providers to request authorizations without the need to call or fax Healthfirst. To access the Online Authorization Request tool, log in to the Secure Healthfirst Provider Portal at **www.healthfirst.org/providers**. You will need your username and password to log in. If you do not have an account, you must create one to access the secure portal. Once logged in, click on the tab or link called "Online Authorization Request."

There are multiple benefits to the Online Authorization Request tool, including:

- 24-hour access that includes weekends and holidays
- Allows you to request an unlimited number of authorizations at one time
- Enables you to attach clinical documentation directly to the authorization
- Provides an authorization reference number as soon as the authorization is submitted
- Allows for status tracking of authorization requests
- Reduces the number of faxes and phone calls to Healthfirst

## How do I submit documentation?

On the "Documentation" step, choose a document and click "Add Attachment."

- Clinical documentation may include prescriptions, imaging studies, letters of medical necessity, test results, or medical notes
- Uploaded files are limited to 5MB in size
- Supported file formats include: bmp, doc, docx, gif, html, jpeg, jpg, mdi, mht, msg, pdf, rtf, tif, tiff, txt, wav, xls, xlsm, xlsx, and xps
- Remove documents by clicking on the Trashcan icon under "Existing Attachments"
- Remove documents prior to Authorization submission by clicking on the "Edit this Information" link on the Review screen

## How do I submit documentation once an authorization has already been submitted?

- Select the "Print a fax cover sheet" icon once the Authorization is submitted. The fax cover sheet will autopopulate the following:
  - Member's Name
  - Member's Healthfirst ID
  - Member's Date of Birth
  - Authorization Request Number
  - Authorization Request Date/Time
- Download and print a prepopulated fax cover sheet from the **My Requests** tab
- Upload and attach documentation to already submitted Authorizations as long as Authorizations begin with "IP" or "OP" and are in Pending Status

Authorization requests will be reviewed, and a determination will be made based on medical necessity as well as on the member's specific plan. For authorization requests that require immediate attention, please call Healthfirst Provider Services at **1-888-394-4327**.

Authorization requests will be reviewed, and a determination will be made based on medical necessity as well as on the member's specific plan.

### Questions?

- Please refer to resources "Frequently Asked Questions" and "Step-by-Step Guidelines on How to Submit Requests" once you log in at **www.healthfirst.org/providers**.
- Email Healthfirst at **ProviderPortal@healthfirst.org**.
- Healthfirst's automated phone system is available 24 hours a day, 7 days a week, at **1-888-394-4327**.

# Medicaid CAHPS Season Starts in September

Healthfirst is committed to providing our members with the highest quality service possible so they can stay healthy. Office wait times and the obtaining of timely appointments are key Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures that impact the patient experience. Performing well on these measures helps increase retention, referrals, and the incentives you receive from Healthfirst.

As you know, the CAHPS survey asks patients to evaluate their experiences with healthcare, including their providers. Our Medicare, Medicaid, FIDA, Qualified Health Plan (QHP), and Essential Plan (EP) members receive this survey annually through a certified vendor on behalf of the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health.

**Select Child Medicaid members will get the CAHPS survey between September and December.**

Today's patients expect to be seen at your office as soon as possible. They desire greater levels of customer service and support to be satisfied and return to your practice.

We've found that today's patients expect to be seen at your office as soon as possible, and that they desire greater levels of customer service and support to be satisfied and return to your practice.

To help ensure appropriate access to care for your Healthfirst patients and perform well on the CAHPS survey, we recommend that you:

- Schedule appointments in a timely manner (two weeks or less is optimal)
- Help book appointments to specialists or facilities you are referring them to
- Update your demographic information as needed
- Ensure your phone system is working and avoid long hold times

You can help improve our members' experience during this critical survey period by:

- Visiting **www.healthfirst.org/PatientSatisfaction** to review strategies you can implement in your practice to improve the patient experience and continuously perform well on access and availability surveys
- Learning more about Access and Availability and Phone Operations
- Checking out our CAHPS Frequently Asked Questions
- Addressing CMS Standards

# Access to Specialty Care

Did you know that obtaining a timely specialist appointment is one of Healthfirst members' biggest challenges? The good news is that you can help your patients access specialty care more easily. Whenever you provide a referral to a specialist, just make sure that your staff follows these best practices:

- Confirm that the specialist accepts the patient's Healthfirst plan by visiting **HFDocFinder.org** to see if the specialist is a participating provider. You can also visit **www.healthfirst.org/PatientSatisfaction** to check out our how-to guide. (locate article titled, "Helping Healthfirst members access the care they need")

- Once you've found the right specialist for the patient, help them call the specialist's office to schedule their appointment before they leave. This is the first step in making sure your patient's follow-up care needs are met, which helps to improve their satisfaction

- After the appointment is scheduled, promptly send any necessary medical records or information to the selected specialist

# Health Outcomes Survey (HOS) Measures Impact Medicare Star Ratings

## Three Key Conversations You Should Be Having With Medicare Patients

During a Medicare patient's primary care visit, it is important to ask the patient about overall physical well-being. It is especially important to assess and ask Medicare patients about physical activity, risk for falling, and any issues with bladder control, as these may not be topics patients themselves bring up to physicians.

### Physical Activity

Physicians should ask patients about their lifestyle and physical activities to assess if the patient is getting enough physical activity. Based on the activity levels the patient reports, physicians may recommend that the patient start, increase, or maintain their level of exercise or physical activity. Physicians may ask their patients to start taking the stairs, increase walking from 10 to 20 minutes every day, or maintain their current exercise routine.

### Fall Risk

Physicians should assess a patient's risk of falling by asking:

- Have you fallen in the past year?
- Have you had any problems with balancing or walking?
- Do you feel unsteady when standing or walking without a support (a cane, for instance)?

Patients who previously had a fall or problems with balancing or walking may be at risk of falling or injuring themselves again. Physicians should identify whether their patients are at risk, discuss appropriate interventions to reduce this risk, and provide treatment. Physicians may recommend that their patients participate in physical therapy, conduct a vision or hearing test, or use a cane or walker.

### Bladder Control

Physicians should ask patients if they've experienced any problems with urinary incontinence and discuss appropriate treatment. By having these discussions and interventions in place, we can help keep our members safe and healthy.

# Additional resources for your Healthfirst Medicare Advantage patients who might need financial assistance

We know how hard it can be for some of your Healthfirst Medicare Advantage patients to keep up with all the costs in their life—whether it's paying for rent, food, electricity, or medical bills. That's why we're pleased to tell you about **My Advocate**, a program open to **all Healthfirst Medicare Advantage members who may need financial help**.

With **My Advocate**, your Healthfirst Medicare Advantage patients get connected to local health and financial programs that offer:

- Medicine discounts
- Help with copays and Medicare Part B premiums
- Transportation discounts
- Meals and other food options
- Reduced rates for energy bills
- And more

Your Healthfirst Medicare Advantage patients may call **My Advocate** at **1-866-620-4995** (TTY 1-855-368-9643), Monday to Friday, 9am–6pm, or visit **My Advocate** at **www.myadvocatehelps.com** to find out which programs may be right for them. **My Advocate** will ask your patients questions about their finances to determine which programs they might be eligible to receive. All information will be kept private and confidential.

# The Flu Shot and Your Healthfirst Patients

At Healthfirst, our members and their health come first. With flu season upon us, we know you share in our goal of protecting our members and their families from sickness.

Talk to your patients who are Healthfirst members about getting the flu vaccine. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccine for anyone over the age of six months. A flu vaccine is also especially important for pregnant women, adults over 65, and anyone with a chronic medical condition.

If the vaccine is not available at your office, please have the Healthfirst member call us so we can help them find the nearest location at which it is available.

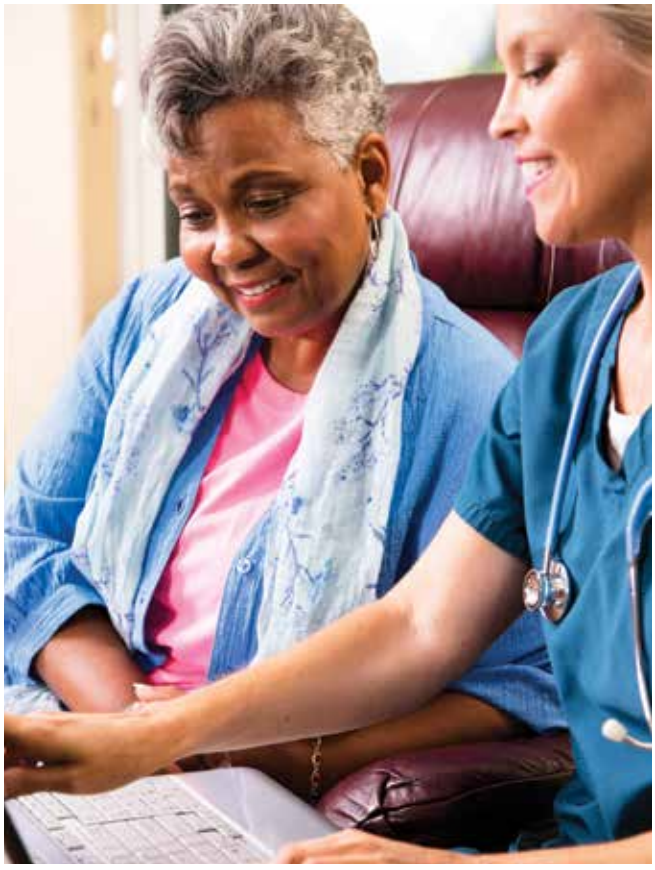
Medicare: **1-888-260-1010**, 7 days a week, 8am–8pm;
Medicaid: **1-866-463-6743**, Monday to Friday, 8am–6pm,
TTY 1-888-542-3821 English/1-888-867-4132 Spanish (Español).

Additional resources for healthcare professionals—including key information about prevention, treatment, and diagnosis of the flu—and patient education tools for your practice are available at: **www.cdc.gov/flu/about/qa/flushot.htm**.

The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccine for anyone over the age of six months.

# My Patients Are Turning 65. What Are Their Options?

When patients of yours turn 65, they may have questions about their insurance options as they become eligible for Medicare. You can help your patients maintain affordable, high-quality coverage when they turn 65 by encouraging them to visit **www.medicare.gov**. There they can view plans available in their area and compare plans based on price and quality ratings.



Among their options is a Healthfirst Medicare Advantage plan. Healthfirst Medicare Advantage HMO plans are the only plans in NYC to achieve 4 stars out of a 5-star rating three years in a row, as rated by the Centers for Medicare & Medicaid Services. Healthfirst offers a variety of Medicare plans for all lifestyles and financial situations, including plans designed for low-income individuals who are eligible for Medicaid or Extra Help from Social Security to help them pay for prescription drug coverage.

Your patients can learn more about Healthfirst's Medicare plans by:

- Visiting the Healthfirst website at **www.healthfirst.org**
- Coming to a local Healthfirst Community Office
- Calling us at **1-877-237-1303** (TTY 1-888-542-3821), 7 days a week, 8am–8pm

## As a Healthfirst provider, what am I allowed to tell my patients with regard to the plan?

**You may**

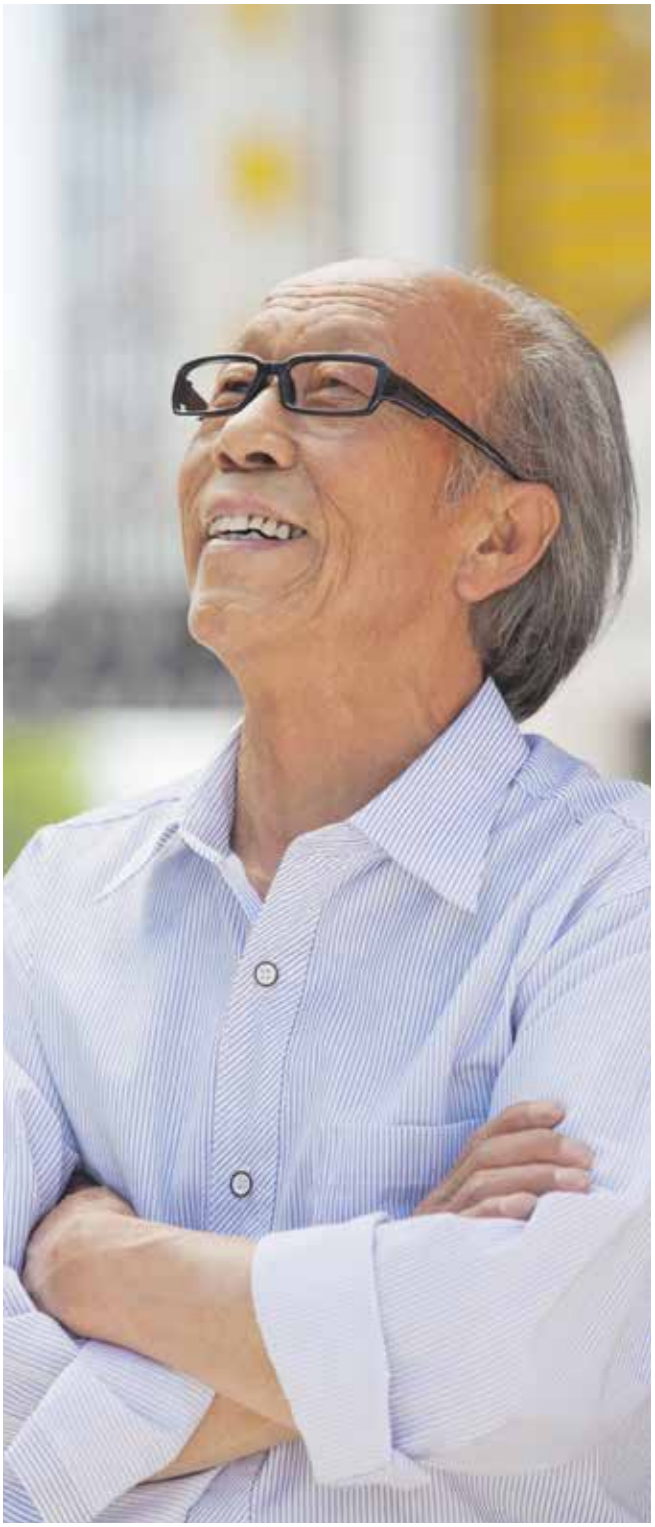
- Make available Healthfirst Medicare Advantage marketing materials in common areas, as long as any other Medicare health plan that asks the same for their plans is accommodated. Please note that you cannot provide these materials within an exam room setting
- Refer your patients to other sources of information, such as the local Social Security Office or the CMS website at **www.medicare.gov**
- If your patient specifically asks about Healthfirst plans, you can refer them to our website at **www.healthfirst.org**
- Share information from the CMS website with your patients, including the *Medicare and You* handbook or the *Medicare Options Compare* or other documents that were written by or approved by CMS

**You may not**

- Accept enrollment applications or complete an enrollment application on behalf of a beneficiary
- Make phone calls or direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests you may have
- Send marketing materials on behalf of Healthfirst or any other Medicare health plan
- Offer anything of value to induce enrollees to select you as their provider of healthcare
- Offer inducements to persuade beneficiaries to enroll in Healthfirst or in any other Medicare health plan
- Accept compensation directly or indirectly from Healthfirst or any other Medicare plan for enrollment activities

## What materials are available to providers?

You may contact Provider Services at **1-888-801-1660**, Monday to Friday, 9am–5pm, for provider-related information.



# CVS/Caremark Mail-Order Program

- Healthfirst works with CVS/Caremark to manage members' prescription benefits. Please encourage your patients who take maintenance medications to enroll in a mail-order prescription drug service.
- With the CVS/Caremark Mail-Order Program, members can save time and money by having certain prescriptions delivered directly to their home by mail, instead of having to go to back and forth to a network pharmacy for each refill. Usually, these are medicines members take on a regular basis, such as thyroid, diabetes, heart, asthma, or high cholesterol medications.
- Here are the advantages they'll get from enrolling in this program:
  - Prescriptions mailed to their home, doctor's office, or anywhere else, with FREE shipping
  - 90-day supplies (or max allowed by plan/doctor) to help with medication adherence and staying on track with their treatment plan
  - Lower prescription drug costs (compared to traditional brick-and-mortar drugstores)
  - Fewer trips to the pharmacy and less time spent waiting to pick up prescriptions
- The mail-order supply is available at 2X the copayment price of the 30-day retail supply for all Essential Plan, QHP Leaf Premier Plans, and Total/Pro/Pro Plus EPO Plans.
- If a patient wishes to enroll in the Healthfirst mail-order prescription drug service benefit, please have them mail the CVS/Caremark Mail Service Order form to:
  - CVS/Caremark
    P.O. Box 94467
    Palatine, IL 60094-4467
  - The order form is available at healthfirst.org or by logging into their secure Healthfirst account at **MyHFNY.org**

With the CVS/Caremark Mail-Order Program, members can save time and money by having certain prescriptions delivered directly to their home by mail, instead of having to go to back and forth to a network pharmacy for each refill.

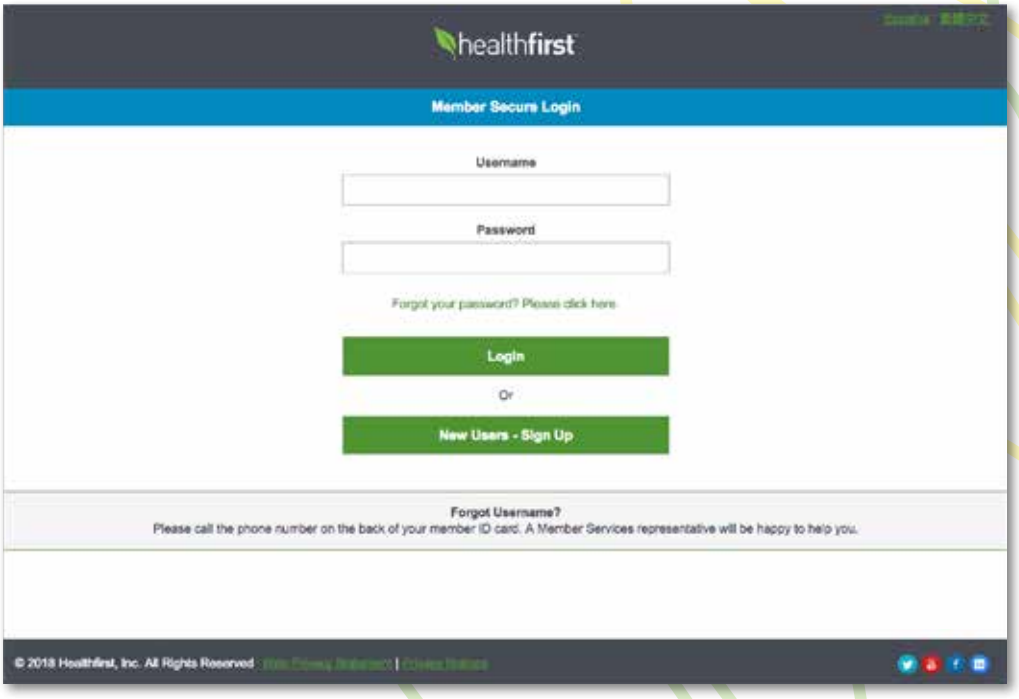
## Questions?

Call CVS/Caremark at **1-800-552-8159**, 24 hours a day, 7 days a week.

# Secure Member Portal Account

Encourage your Healthfirst members to set up a secure MyHealthfirst account at **MyHFNY.org** so that they can manage their plan benefits online. Setting up an account will allow them to:

- Request a new Member ID card and/or print a temporary one
- Change their PCP
- View recent medical services and authorizations
- View pharmacy benefits through CVS/Caremark
- Find a doctor, pharmacy, or clinic
- Review their plan benefits
- Set up phone, email, and text preferences
- Estimate treatment costs
- View and pay their premiums online
- Check their deductible and out-of-pocket costs



# Keep Your Profile Current

Keeping updated contact information is essential for ensuring appropriate access to care for our members.

To avoid a poor experience for our members, we at Healthfirst want to ensure our directory has the most up-to-date information for your practice.

As you are aware, we conduct audits throughout the year to ensure you are providing timely access to appointments and that your demographic information is up-to-date.

Remember, your information matters to us, but more importantly it impacts our members. It takes only one wrong phone number or office address for the member to perceive a barrier to accessing their care. Access and availability is essential to our star rating, but more importantly to a healthy and happy member experience. Below are directions for how to easily update your information.

## Provider Information

Providers are responsible for contacting Healthfirst to report any changes in their practice. It is essential that Healthfirst maintain an accurate provider database in order to ensure proper payment of claims and capitation, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Changes and updates should be submitted at least thirty days before the effective date.

It takes only one wrong phone number or office address for the member to perceive a barrier to accessing their care. Access and availability is essential to our star rating, but more importantly to a healthy and happy member experience.

Any changes to the following list of items should be reported to Healthfirst via our electronic Demographic Change Form, found on our secure provider portal at **www.healthfirst.org/providers**. Changes can also be faxed to Healthfirst at **1-646-313-4634/Attn: Demographic Update Request**. These should be submitted with a fax cover sheet that includes full contact information, along with a comprehensive request on the provider or group letterhead that includes the provider's license number and identifies the practice record for update. Any supporting documentation (such as a W-9 form or a board certificate) should be faxed with these requests.

- Update in the provider or group name and tax ID number (W-9 required)
- Update in provider/group practice address, zip code, telephone, or fax number (full practice information required)
- Update in the provider/group billing address (W-9 required)
- Update in the member age limits for service at the practice (if applicable)
- Update in NY license, such as a new number, revocation, or suspension (new certificate or information on action required, if applicable)
- Closure of a provider panel (reason for panel closure)
- Update in hospital affiliation (copy of current and active hospital privileges)
- Update or addition of specialty (copy of board certificate or appropriate education information)
- Update in practice's office hours
- Update in provider's board eligibility/board certification status
- Update in participation status
- Update in NY Medicaid Number (if applicable)
- Update in National Provider Identification Number (if applicable)
- Update in wheelchair accessibility
- Update in covering provider
- Update in languages spoken in the provider's office


It is essential that Healthfirst maintain an accurate provider database in order to ensure proper payment of claims and capitation, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members.

# ICD-10-CM Coding Tips for Diabetes with Complications

One of the big changes in ICD-10-CM is the assumed causal relationship between two conditions, for which they no longer require linking terms such as "with" or "in" to mean "associated with" or "due to" when it appears under the Diabetes code title. These conditions should be coded as related even in the absence of provider documentation explicitly linking them. However, this rule does not apply when the documentation clearly states the conditions are unrelated. Formerly, each of the complications indented in the diabetes Alphabetic Index below had to be clearly documented as a diabetes-related condition before it could be coded and reported.

## Coding and Reporting Diabetes Mellitus

Diabetes Mellitus is among the most common inaccurately reported chronic conditions. A frequent mistake is to incorrectly report diabetes as "diabetes without complications" when this condition was previously confirmed with complications/manifestations. In diabetes coding, you can use as many codes from categories E08–E13 as needed to describe all the complications and the associated conditions of a patient's disease as confirmed and reported within the medical record documentation.

These mistakes affect reporting accuracy, which is required in capturing a patient's full health status profile. Complete and accurate diagnostic reporting helps to ensure appropriate resources to manage a patient's conditions. A note of caution: an EMR system does not always yield precise coding; it may provide a misleading pathway to connect or unlink selected diagnostic codes to certain comorbid conditions or manifestations. For proficiency, accurately connect the dots of a disease etiology to a manifestation or complication based on a solid understanding of the causal relationship between the two or more conditions of the rendering provider's assessment.

In diabetes coding, you can use as many codes from categories E08–E13 as needed to describe all the complications and the associated conditions of a patient's disease as confirmed and reported within the medical record documentation.

Below is a reference tool to review and become familiar with the subterms under "Diabetes 'with'" in the codebook Alphabetic Index:

**Diabetes, diabetic** (mellitus) (sugar) E11.0 with

- amyotrophy E11.44
- arthropathy NEC E11.618
- autonomic (poly) neuropathy E11.43
- cataract E11.36
- Charcot's joints E11.610
- chronic kidney disease E11.22
- circulatory complication NEC E11.59
- complication E11.8
  - specified NEC E11.69
- dermatitis E11.620
- foot ulcer E11.621
- gangrene E11.52
- gastroparesis E11.43
- glomerulonephrosis intracapillary E11.21
- glomerulosclerosis, intercapillary E11.21
- hyperglycemia E11.65
- hyperosmolarity E11.00
  - with coma E11.641
- kidney complications NEC E11.29
- Kimmelsteil-Wilson disease E11.21
- loss of protective sensation **(LOPS)** – see Diabetes, by type, with neuropathy
- mononeuropathy E11.41
- myasthenia E11.44
- necrobiosis lipoidica E11.620
- nephropathy E11.21
- neuralgia E11.42
- neurologic complication NEC E11.49
- neuropathic arthropathy E11.60
- neuropathy E11.40
- ophthalmic complication NEC E11.39
- oral complication NEC E11.638
- periodontal disease E11.630
- peripheral angiopathy E11.51
  - with gangrene E11.52
- polyneuropathy E11.42
- renal complication NEC E11.29
- renal tubular degeneration E11.29
- retinopathy E11.319
  - with macular edema E11.311
  - nonproliferative E11.329
    - with macular edema E11.321
    - mild E11.329
      - with macular edema E11.321
    - moderate E11.339
      - with macular edema E11.331
    - severe E11.349
      - with macular edema E11.341
  - proliferative E11.359
    - with macular edema E11.351
- skin complication NEC E11.628
- skin ulcer NEC E11.622

As stated in the coding guidelines and the Coding Clinic clarification, if diabetes mellitus and any of the indented conditions in the Alphabetic Index provided above are present in the documentation, use the combination code/s next to the condition unless it explicitly documented that the diabetes is not the underlying cause of the condition.

Take a look at the samples below and determine the reportable diagnosis codes:

**Documentation Sample 1:**
A type 2 diabetic patient is admitted with cataract, polyneuropathy, and stage 3 chronic kidney disease due to hypertension.

**The code selections are:**
**E11.36 –** Type 2 diabetes mellitus with diabetic cataract

**E11.42 –** Type 2 diabetes mellitus with diabetic polyneuropathy

**I12.9 –** Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

**N18.3 –** Chronic kidney disease, stage 3 (moderate)

*Continued on pg. 24*

## ICD-10-CM Coding Tips for Diabetes with Complications

*Continued from pg. 23*

### Coding Rationale

Since ICD-10-CM assumes a causal relationship between diabetes and the cataract as well as the polyneuropathy, these conditions should be reported as diabetes complications, with the exception of the CKD, as it clearly states this condition is due to hypertension. Thus, the CKD should not be reported as a diabetic complication.

**Documentation Sample 2:**
Fifty-year-old male with type 2 diabetes mellitus, age-related cataracts, postherpetic polyneuropathy came for medication refill.

**The code selections are:**
**E11.9 –** Type 2 diabetes mellitus without complications

**H25.9 –** Unspecified age-related cataract

**B02.23 –** Postherpetic polyneuropathy

### Coding Rationale

In this sample, we cannot assume a linkage between diabetes and cataract, and the postherpetic polyneuropathy. The cataract is age related, while the polyneuropathy is a complication of shingles; thus both are not diabetes complications.

**Tips and recommendations to ensure appropriate codes are assigned to a diabetes diagnosis:**

- Review the above diabetes listing carefully, then go to the Tabular to confirm the correct code selection/assignment
- Check for any other guideline/s that may exist that specifically requires a documented linkage between two conditions, as this may also impact code selection
- Remember to always code and report a diagnosis to the highest degree of specificity and certainty
- Refer to **www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf** and the AHA Coding Clinic, First Quarter 2016, page 11, for complete information
- Lastly, audit your EMR system to ensure that these diabetes mellitus codes are available in your code selections

**Remember:** Before assigning **E11.9 – Diabetes mellitus without complication**, always review the documentation carefully to confirm that none of the diagnosis or conditions in the medical notes is under the diabetes mellitus subterms "with."


OK

# Clinical Partnerships

## Care for Older Adults - **H**elping yo**U** a**G**e **S**afely **(HUGS)** Pilot Program in the Bronx

This fall, the Healthfirst Clinical Partnerships team is collaborating with the Regional Aid for Interim Needs (R.A.I.N), Inc. organization to assist Medicare members by addressing the social needs of older adults in the Bronx.

According to Susan J. Beane, MD, Vice President and Medical Director, "Healthfirst understands the importance of aligning clinical care and treatment plans by our primary care practices with community-based services to address the health goals of members holistically."

R.A.I.N. will be assessing the needs of older adults in the 10456, 10457, and 10458 zip codes to determine needed services. R.A.I.N. social workers will utilize an assessment tool, The Healthfirst Patient Perception of Health Survey, that was created in collaboration with Healthfirst providers. The HUGS Program will be offered via an online platform, PeerPlace®, to streamline referrals to service providers who can meet the needs of Healthfirst Medicare members. The program will offer support with the following services, based on the identified needs of Healthfirst members:

- Assistance with applications for benefits and entitlements
- Telephone reassurance calls
- Mt. Carmel Neighborhood Senior Center for participation in one or more of the following senior center activities – Congregate meals, exercise classes, health management classes, transportation to/from senior center
- Access-A-Ride, Reduced Fare Metro
- Home-Delivered Meals
- Alzheimer's Caregiver Link Program
- Connection to Healthfirst Care Management, Healthfirst Behavioral Health Care Management, or Healthfirst Member Services and/or connection to their primary care providers and in-home physical and/or occupational therapy

The R.A.I.N HUGS Program Collaboration is a six-month pilot that will be taking place during the fall 2018 season. If there is a Healthfirst Medicare member living in zip codes 10456, 10457, or 10458 who could benefit from participating in this Pilot Program, please contact Gina DiLorenzo at **1-212-519-1777**. Both Healthfirst providers and members can inquire about participation in this program.

## 2018 Spring Symposium – Addressing the Health Needs and Goals of Millennial New Yorkers

Healthfirst hosted its annual Spring Provider Symposium on June 1 at The New York Academy of Sciences. These symposia provide an opportunity to share best practices and hear about advances from leaders seeking to transform the healthcare system, raise quality of care for consumers, and improve health outcomes for all New Yorkers.

"Understanding the unique healthcare needs and preferences of our members is vital so that Healthfirst can continue its 25-year tradition of providing access to high-quality care," said Susan Beane, MD, Healthfirst Vice President and Medical Director, whose Clinical Partnerships program has shepherded the Provider Symposium

series since its inception seven years ago. "Much like the generations that came before them, Millennials will face their own unique challenges, and today's panel of speakers will offer the kind of insights into this population that will make a significant impact on how our providers treat these members."

Left to right: Tom Meixner, Senior Vice President, Delivery Systems Engagement, Healthfirst; Mireille Seneclauze Mclean, MA, MPH, Deputy Director of Programs, Public Health Solutions; Denard O. Cummings, MPA; Susan J. Beane, MD, Vice President and Medical Director, Clinical Partnerships, Healthfirst; Jonathan Zipkin, MD, MA, FAAP; Marissa Martin, LMSW; Fabienne Laraque, MD, MPH; David Nemiroff, LCSW; and Paul Portsmore, Senior Vice President, Growth, Healthfirst

The symposium featured presentations by the following speakers:

- "Improving Health Outcomes by Addressing the Social Determinants of Health" — Denard O. Cummings, MPA, Director, Bureau of Social Determinants of Health, Division of Program Development and Management, New York State Department of Health
- "Better Tech is Not Enough: The Case for Public Health Service Delivery Reform" — Mireille Seneclauze Mclean, MA, MPH, Deputy Director of Programs, Public Health Solutions
- "Transformative Urgent Care for the Digital Era" — Jonathan Zipkin, MD, MA, FAAP, Regional Lead Physician – Manhattan, Brooklyn, Staten Island and Regional Medical Informatics Officer – NY Market for Northwell Health – GoHealth Urgent Care
- "New York City Department of Homeless Services: Opioid Overdose Prevention" — Fabienne Laraque, MD, MPH, Medical Director, New York City Department of Homeless Services/Department of Social Services
- "Innovations for the New Millennial: Generation Y" — David Nemiroff, LCSW, President and Chief Executive Officer, Long Island FQHC, Inc.
- "Forging Opportunities: Local Initiatives Support Corporation" — Shai J. Lauros, Msc. RUP, MArch, National Health Director, Local Initiatives Support Corporation
- "Health Outreach and Messaging for Young Adults" — Marissa Martin, LMSW, Northeast Director, Young Invincibles

To learn more about our speakers and view their presentations, please visit **www.healthfirst.org/ClinPartnerships**.

# Advance Directives

How can you help your patients plan for their future? Here you'll find the resources you need to guide them through important decisions.

There may come a time when your patients can't decide about their own healthcare. Advise them that by planning in advance, they can arrange now for their wishes to be carried out. In addition to family and friends, your patients may want to let you know what kinds of treatment they do or do not want. Examples of the types of care that may be addressed in an advance directive include the use of ventilators, intubations, and other life-saving procedures, as well as the areas of nutrition and hydration therapy. Let them know they can appoint an adult they trust to make decisions for them. You can also mention it is best if they put their thoughts in writing.

The National Quality Forum Framework and Preferred Practices for Quality Hospice and Palliative Care outline preferred practices for advance care planning:

- Document the designated surrogate/decision-maker in accordance with state law for every patient in primary, acute, and long-term care and in palliative care and hospice care
- Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as conditions change
- Convert the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital, such as the Physician Orders for Life-Sustaining Treatment (POLST) program
- Make advance directives and surrogacy designations available across care settings, while protecting patient privacy and adherence to HIPAA regulations; e.g., by internet-based registries or electronic personal health records
- Develop healthcare and community collaborations to promote advance care planning and completion of advance directives for all individuals; e.g., Respecting Choices, Community Conversations on Compassionate Care. Healthcare, legal, and all community professionals have an opportunity and a professional obligation to collaborate and make these preferred practices a reality in New York State

Conversations should be based on the individual's behavioral readiness to complete an advance directive.

## Provider Resources

- Healthcare proxy can be found at **www.health.ny.gov/publications/1430.pdf**
- 2018 HEDIS Care for Older Adults CPT/CPTII/HCPS Codes

## 2018 HEDIS Care for Older Adults CPT/CPTII/HCPCS Codes

| Code | Measure Impact | Code Description | LOBs | Premium Group | Age Band | PCP Only | Payment* |
|---|---|---|---|---|---|---|---|
| 99497 | Care for Older Adults (COA) | Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) by the physician or other qualifiedhealthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate | SNP LIP65+ | NYAC1, FDA200, FDA300, FDAN02, FDAN03, FDAS02, FDAS03, FDAW02, FDAW03 | 66+ | Yes | $5.00 |
| 1123F | | Advance care planning discussed and documented advance care plan or surrogate decision-maker documented in the medical record | | | | | |
| 1124F | | Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan | | | | | |
| 1157F | | Advance care plan or similar legal document present in the medical record (COA) | | | | | |
| 1158F | | Advance care planning discussion documented in the medical record (COA) | | | | | |
| S0257 | | Counseling and discussion regarding advance directives orend-of-life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service) | | | | | |
| 90863 | Care for Older Adults (COA) | Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure) | SNP LIP65+ | NYAC1, FDA200, FDA300, FDAN02, FDAN03, FDAS02, FDAS03, FDAW02, FDAW03 | 66+ | Yes | $5.00 |
| 99605 | | Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment andintervention if provided; initial 15 minutes, new patient | | | | | |
| 99606 | | Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment andintervention if provided; initial 15 minutes, established patient | | | | | |
| 1159F | | Medication list documented in medical record (COA) | | | | | |
| 1160F | | Review of all medications by a prescribing practitioner or clinical pharmacist (such as prescriptions, OTCs, herbal therapies,and supplements) documented in the medical record (COA) | | | | | |
| G8427 | | Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications | | | | | |
| 1170F | Care for Older Adults (COA) | Functional status assessed (COA) | SNP LIP65+ | NYAC1, FDA200, FDA300, FDAN02, FDAN03, FDAS02, FDAS03, FDAW02, FDAW03 | 66+ | Yes | $5.00 |
| 1125F | Care for Older Adults (COA) | Pain severity quantified; pain present (COA) | SNP LIP65+ | NYAC1, FDA200, FDA300, FDAN02, FDAN03, FDAS02, FDAS03, FDAW02, FDAW03 | 66+ | Yes | $5.00 |
| 1126F | | Pain severity quantified; no pain present (COA) (ONC) | | | | | |

*Effective 5/1/18

Source:
www.compassionandsupport.org/index.php/for_professionals/advanced_care_planning_-_professionals

# HEDIS Measures

## Breast Cancer Screening

You can help your patients take steps to reduce their risk of developing breast cancer. Some women who have breast cancer have no signs or symptoms. Early detection can help prevent the breast cancer from spreading to other parts of the body.

In New York City:

- Doctors diagnose women with breast cancer more often than any other type of cancer, except for skin cancer.
- Breast cancer is the second-leading cause of cancer death for women, after lung cancer. More than 1,000 women die from breast cancer each year.

**Risk Factors**
Our members are more likely to get breast cancer if they:

- Are a woman (men can also get breast cancer; however, it is rare)
- Are older (the older you get, the higher your risk)
- Don't exercise regularly
- Are obese
- Drink alcohol (drinking even a small amount of alcohol can increase the risk for breast cancer)
- Take combination estrogen-progesterone hormone replacement therapy during menopause
- Currently use certain birth control pills
- Had breast cancer previously, or have a family history of breast cancer
- Have a specific gene mutation for breast cancer, such as BRCA1 or BRCA2
- Began menstruation early (before age 12) or menopause late (after age 55)

Try to address risk factors with your patients. This could help them prevent cancer.

## Early detection can help prevent the breast cancer from spreading to other parts of the body.

**Screening**
Research indicates routine screenings can help doctors find breast cancer early, when it is easier to treat.

The most common way to screen for breast cancer is a mammogram. Mammograms can spot breast cancer before patients can feel lumps in the breast.

If your patients are 40 or older, discuss the benefits and risks of breast cancer screening and when to start screening. Some women need to be screened earlier than others, depending on their risk factors. If they have a family history of breast cancer, talk to them about getting screened before age 40. The NYC Department of Health does not recommend screening by self-examination of the breast.

Source: www1.nyc.gov/site/doh/health/health-topics/breast-cancer.page

The most common way to screen for breast cancer is a mammogram. Mammograms can spot breast cancer before patients can feel lumps in the breast.

**Measure Description: Breast Cancer Screening (BCS)**
**The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.**

**Product lines:** Medicaid, Medicare, HARP, QHP, EP

**Ages:** 52–74 years of age as of December 31 of the measurement year. The difference of age is due to the two-year look back. A member that turns 52 in 2017 and had a mammogram two years ago would be adherent, as they were 50 years of age at the time of service.

**Continuous Enrollment:** October 1 two years prior to the measurement year through December 31 of the measurement year.

**Allowable Gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year

**Anchor Date:** December 31 of the measurement year

**Denominator:** Eligible population

**Numerator:** One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year (October 1, 2015 to December 31, 2017).

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## HEDIS Measures

*Continued from pg. 31*

**Exclusion (Optional):**

- Women who had a bilateral mastectomy—as far back as possible in the member's history through December 31 of the measurement year
- A unilateral mastectomy code with a bilateral modifier. Codes must be on the same claim
- Two unilateral mastectomy codes with service dates 14 days or more apart. For example, if the DOS of the first unilateral mastectomy was February 1 of the measurement year, the DOS for the second unilateral mastectomy must be on or after February 15
- A history of bilateral mastectomy code
- Any combination of codes that indicate a mastectomy on both the left and right side on the same or different dates of services
- Members in hospice are excluded from the eligible population

**Note:** This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, MRIs, or tomosynthesis (3D mammography); they are not appropriate methods for primary breast cancer screening.

| CPT Codes to Identify Breast Cancer Screening | |
|---|---|
| 77055 | Mammography; unilateral |
| 77056 | Mammography; bilateral |
| 77057 | Screening mammography, bilateral (2-view study of each breast) |
| 77061 | Digital breast tomosynthesis; unilateral |
| 77062 | Digital breast tomosynthesis; bilateral |
| 77063 | Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure) |
| 77065 | Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral |
| 77066 | Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral |
| 77067 | Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed |

**Tips to Share:**

- This measure evaluates primary screening. Biopsies, breast ultrasounds, MRIs, or tomosynthesis (3D mammography) are not counted because they are not appropriate methods for primary breast cancer screening
- View and download HEDIS resources at **www.healthfirst.org/HEDIS**


## Cervical Cancer Screening

Each year in NYC, more than 400 women are diagnosed with cervical cancer and nearly 150 women die from the disease. Some women who have cervical cancer show no signs or symptoms.

Talk to your patients about taking steps to reduce their risk of developing cervical cancer. Vaccination and early detection can help prevent cervical cancer from forming.

Screening can prevent cancer or find the cancer early, when it is easier to treat. Discuss getting a Pap test with your female patients to look for cervical cancer.

The most common cause of cervical cancer is infection with a virus called human papillomavirus (HPV).

**Risk Factors**

The most common cause of cervical cancer is infection with a virus called human papillomavirus (HPV). This common virus is passed from one person to another during sex. Most sexually active people get an HPV infection at some time in their lives, but only some women who have it will get cervical cancer.

Your patients may also be more at risk for cervical cancer if they:

- Smoke
- Take birth control pills for an extended time (five or more years)
- Have HIV or another condition that weakens their immune system

**Measure Description**

**Cervical Cancer Screening (CCS)**

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every three years
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years

**At Healthfirst, as partners with our providers in providing the best possible healthcare to our members, what are we looking for?**

For women 24–64 years of age as of December 31, 2017, documentation in the medical record of the following:

- A note in the record indicating when the cervical cytology was done
- The result or finding

HEDIS®

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## HEDIS Measures

*Continued from pg. 33*

Note:

- The testing may be in the measurement year (2017) or in any of the two years prior (2015, 2016)
- May count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells (Pap test, thin prep, etc.)
- Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test

For women **30–64** years of age as of December 31, 2017, documentation in the medical record must include:

- A note in the record indicating that both cervical cytology and the HPV test were performed on the same date of service and found in the same data source
- The results or findings of both tests

Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

Note:

- The testing may be in the measurement year (2017) or in any of the four years prior (2013, 2014, 2015, or 2016)
- Include only cervical cytology and HPV co-testing on the same date of service
  - May count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells (Pap test, thin prep, etc.)
  - Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test

**Not Acceptable**

- **Do not count** HPV reflex testing (if the medical record indicates the HPV test was performed only after the cytology result. This is considered reflex testing and does not meet criteria)
- Do not count biopsies; they are diagnostic and therapeutic only

- Do not count lab results that explicitly state the sample was "inadequate" or that "no cervical cells were present"; this is not considered appropriate screening
- An HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate

**Exclusion Criteria**

- Evidence of a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix any time during the member's history through December 31, 2017. Documentation of "complete," "total," or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix
- Documentation of a "vaginal Pap smear," in conjunction with documentation of "hysterectomy"
- Documentation of hysterectomy in combination with documentation that the patient no longer needs Pap testing/cervical cancer screening

Note: Documentation of hysterectomy alone does not meet the criteria; it is not sufficient evidence that the cervix was removed.

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## HEDIS Measures

*Continued from pg. 35*

| CPT Codes to Identify Cervical Cancer Screening | |
|---|---|
| 88141 | Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician |
| 88142 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision |
| 88143 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision |
| 88147 | Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision |
| 88148 | Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision |
| 88150 | Cytopathology, slides, cervical or vaginal; manual screening under physician supervision |
| 88152 | Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision |
| 88153 | Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision |
| 88154 | Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision |
| 88164 | Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision |
| 88165 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision |
| 88166 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision |
| 88167 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision |
| 88174 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision |
| 88175 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision |

The following is from the U.S. Department of Health & Human Services at: **www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/section2a.html.**

**Additional Resources**

- American Cancer Society: About Cervical Cancer – **www.cancer.org**
- Centers for Disease Control and Prevention: Cervical Cancer – **www.cdc.gov**
- Centers for Disease Control and Prevention: Human Papillomavirus (HPV) – **www.cdc.gov**
- National Cancer Institute: Cervical Cancer – Patient Version – **www.cancer.gov**

Source: www1.nyc.gov/site/doh/health/health-topics/cervical-cancer.page

## Colorectal Cancer Screening

According to the CDC, colorectal cancer screening saves lives. Colorectal cancer is the second leading cancer killer in the United States. Advise your patients who are 50 or older that getting a colorectal cancer screening test could save their life. Explain to your patients that colorectal cancer usually starts from precancerous polyps in the colon or rectum, that a polyp is a growth that shouldn't be there, and that over time some polyps can turn into cancer. Screening tests can find precancerous polyps so they can be removed before turning into cancer. Screening tests also can find colorectal cancer early, when treatment works best.

Explain to your patients that colorectal cancer usually starts from precancerous polyps in the colon or rectum, that a polyp is a growth that shouldn't be there, and that over time some polyps can turn into cancer.

**Who Gets Colorectal Cancer?**
Both men and women can get it. It is most often found in people 50 or older. The risk increases with age.

**Are Your Patients at Increased Risk?**
Your patient's risk for colorectal cancer may be higher than average if:

- They or a close relative have had colorectal polyps or colorectal cancer
- They have inflammatory bowel disease, Crohn's disease, or ulcerative colitis
- They have a genetic syndrome such as familial adenomatous polyposis (FAP) or hereditary nonpolyposis colorectal cancer

People at increased risk for colorectal cancer may need earlier or more frequent tests than other people.

**Colorectal Cancer Can Start with no Symptoms**
Precancerous polyps and early-stage colorectal cancer don't always cause symptoms, especially at first. This means that your patients could have polyps or colorectal cancer and not know it. That is why having a screening test is so important.

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**What Are the Symptoms?**
Some people with colorectal polyps or colorectal cancer do have symptoms. They may include:

- Blood in or on the stool
- Stomach pain, aches, or cramps that don't go away
- Losing weight and not knowing why

If your patients have any of these symptoms, they may be caused by something other than cancer; however, the only way to know is to see them, talk with your patients, and screen for polyps or colorectal cancer.

**Types of Screening Tests**
The U.S. Preventive Services Task Force recommends that adults aged 50–75 be screened for colorectal cancer. The decision to be screened after age 75 should be made on an individual basis. Several different screening tests can be used to find polyps or colorectal cancer. They include:

- **Stool Tests**
  - Guaiac-based Fecal Occult Blood Test (gFOBT): uses the chemical guaiac to detect blood in stool. Tell your patients at home they can use a stick or brush to obtain a small amount of stool. They return the test to you or a lab, where stool samples are checked for blood
  - Fecal Immunochemical Test (FIT): uses antibodies to detect blood in the stool. Give your patients a test kit and explain this test is done the same way as gFOBT
  - FIT-DNA Test (or Stool DNA test): combines the FIT with a test to detect altered DNA in stool. Your patients collect an entire bowel movement and send it to a lab to be checked for cancer cells
  - **How often: gFOBT once a year. FIT once a year. FIT-DNA once every one or three years.**
- **Flexible Sigmoidoscopy**
  For this test, explain to your patients you put a short, thin, flexible, lighted tube into the rectum. The doctor then checks for polyps or cancer inside the rectum and lower third of the colon. How often: every five years, or every 10 years with a FIT every year.

The U.S. Preventive Services Task Force recommends that adults aged 50–75 be screened for colorectal cancer.

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- **Colonoscopy**
  Similar to flexible sigmoidoscopy, except the doctor uses a longer, thin, flexible, lighted tube to check for polyps or cancer inside the rectum and the entire colon. During the test, the doctor can find and remove most polyps and some cancers. Colonoscopy also is used as a follow-up test if anything unusual is found during one of the other screening tests.
  How often: every 10 years.

- **CT Colonography (Virtual Colonoscopy)**
  Computed tomography (CT) colonography, also called a virtual colonoscopy, uses X-rays and computers to produce images of the entire colon. The images are displayed on a computer screen for you to analyze.
  How often: every five years.

**Which Test Is Right for Your Patients?**

There is no single "best test" for any person. Each test has advantages and disadvantages. Talk to your patients about which test or tests is or are right for them and how often they should be screened.

As partners in healthcare, it is very important that you document in the medical record the type of test, the date the screening was performed, and the required number of returned samples to meet the screening criteria. Also, please do not count digital rectal exam as evidence of a colorectal screening; it is not specific or comprehensive enough to screen for colorectal cancer. Thank you for your continued partnership to continue ensuring that our members in the appropriate age and risk ranges are being screened according to current guidelines.

Source: Centers for Disease Control and Prevention, https://stacks.cdc.gov/view/cdc/45128

As partners in healthcare, it is very important that you document in the medical record the type of test, the date the screening was performed, and the required number of returned samples to meet the screening criteria.

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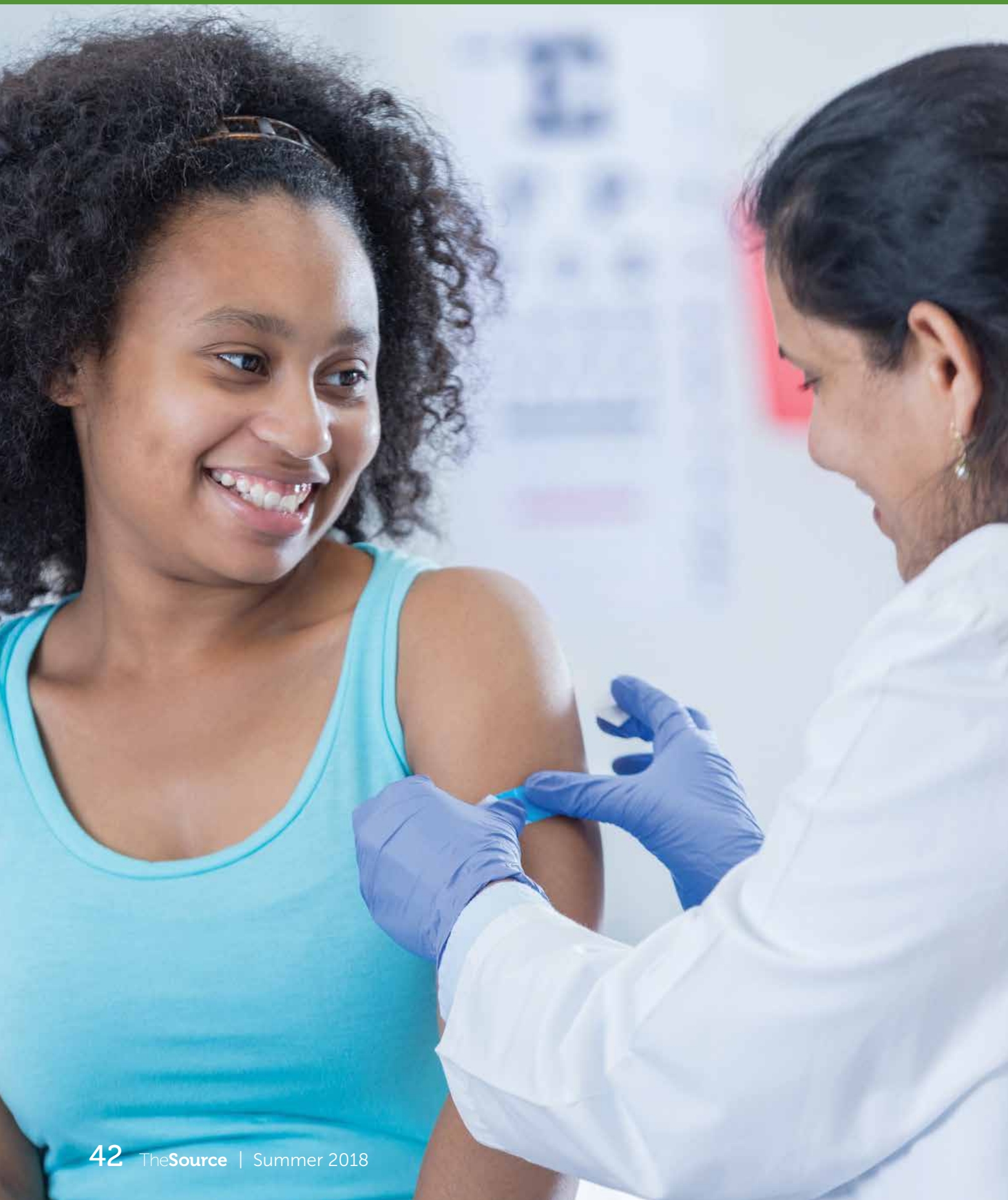
## HEDIS Measures

*Continued from pg. 39*

| 2018 HEDIS Colorectal Cancer Screening (COL) CPT Codes | |
|---|---|
| **FOBT** | |
| 82270 | Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection) |
| 82274 | Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1–3 simultaneous determinations |
| **FIT-DNA** | |
| 81528 | Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result |
| **Flexible Sigmoidoscopy** | |
| 45330 | Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) |
| 45331 | Sigmoidoscopy, flexible; with biopsy, single or multiple |
| 45332 | Sigmoidoscopy, flexible; with removal of foreign body(ies) |
| 45333 | Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps |
| 45334 | Sigmoidoscopy, flexible; with control of bleeding, any method |
| 45335 | Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance |
| 45337 | Sigmoidoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed |
| 45338 | Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique |
| 45340 | Sigmoidoscopy, flexible; with transendoscopic balloon dilation |
| 45341 | Sigmoidoscopy, flexible; with endoscopic ultrasound examination |
| 45342 | Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(ies) |
| 45346 | Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed) |
| 45347 | Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed) |
| 45349 | Sigmoidoscopy, flexible; with endoscopic mucosal resection |
| 45350 | Sigmoidoscopy, flexible; with band ligation(s) (e.g., hemorrhoids) |
| **CT Colonography** | |
| 74261 | Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material |
| 74262 | Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s), including non-contrast images, if performed |
| 74263 | Computed tomographic (CT) colonography, screening, including image postprocessing |
| **Colonoscopy** | |
| 44388 | Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) |
| 44389 | Colonoscopy through stoma; with biopsy, single or multiple |
| 44390 | Colonoscopy through stoma; with removal of foreign body(ies) |

| 2018 HEDIS Colorectal Cancer Screening (COL) CPT Codes *(Cont.)* | |
|---|---|
| **Colonoscopy** *(Cont.)* | |
| 44391 | Colonoscopy through stoma; with control of bleeding, any method |
| 44392 | Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps |
| 44394 | Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique |
| 44401 | Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed) |
| 44402 | Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed) |
| 44403 | Colonoscopy through stoma; with endoscopic mucosal resection |
| 44404 | Colonoscopy through stoma; with directed submucosal injection(s), any substance |
| 44405 | Colonoscopy through stoma; with transendoscopic balloon dilation |
| 44406 | Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures |
| 44407 | Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(ies), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures |
| 44408 | Colonoscopy through stoma; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed |
| 45355 | Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple |
| 45378 | Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) |
| 45379 | Colonoscopy, flexible; with removal of foreign body(ies) |
| 45380 | Colonoscopy, flexible; with biopsy, single or multiple |
| 45381 | Colonoscopy, flexible; with directed submucosal injection(s), any substance |
| 45382 | Colonoscopy, flexible; with control of bleeding, any method |
| 45384 | Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps |
| 45385 | Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique |
| 45386 | Colonoscopy, flexible; with transendoscopic balloon dilation |
| 45388 | Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed) |
| 45389 | Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed) |
| 45390 | Colonoscopy, flexible; with endoscopic mucosal resection |
| 45391 | Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures |
| 45392 | Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(ies), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures |
| 45393 | Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed |
| 45398 | Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids) |

Source: www.cdc.gov/screenforlife



# HIV/AIDS and STD Reminders

According to the Centers for Disease Control and Prevention (CDC), there were approximately 3,123 adults and adolescents diagnosed with HIV in New York in 2015. They also report that there are many teenagers engaging in risky sexual behaviors that result in poor health outcomes due to increased exposure to HIV infection, sexually transmitted diseases (STDs), and unplanned pregnancy. The New York State Department of Health estimates that each year there are 2,375 New Yorkers with a human papillomavirus infection (HPV)-related cancer and that almost two-thirds of these individuals are women.

As Healthfirst providers, we urge you to comply with the HIV/AIDS and STD guidelines noted below to ensure that our members receive their required preventive screenings and the quality care they deserve:

- **New York State Department of Health (NYS DOH) recommends the following:**
  - **Viral Load Suppression –** Children (aged 2 and older) and adults diagnosed with HIV/AIDS should have an HIV viral load less than 200 copies/mL for the most recent HIV viral load test during the measurement year.
- **National Committee for Quality Assurance (NCQA) suggests these preventive services for our members:**
  - **Chlamydia Screening in Women (CHL) –** Women 16–24 years old identified as sexually active should be screened annually for chlamydia.
  - **Immunization for Adolescents (IMA) –** An adolescent should have at least two HPV vaccines or three HPV vaccines as well as one dose of meningococcal conjugate vaccine and one Tdap on or before his or her 13th birthday.
- **NYS Public Health Law & New York City (NYC) Health Code Article 11 mandate the reporting of the following diseases and conditions to the NYC Department of Health & Mental Health:**
  - **HIV/AIDS –** Report all diagnoses of HIV infection, HIV-related illness, and AIDS within 14 days, using the New York State Medical Provider Report Form. Call **1-518-474-4284** for forms, or **1-212-442-3388** for more details.
  - **STD –** Cases should be reported online within 24 hours, using NYCMED **(www1.nyc.gov/site/doh/providers/reporting-and-services/nyc-med.page)**. If necessary, most can also be reported by mailing or faxing the Universal Reporting Form (available at **www1.nyc.gov/assets/doh/downloads/pdf/hcp/urf-0803.pdf**).

For information on HIV/AIDS and STD clinical guidelines, tools, resources, and member educational materials, visit our website at **www.healthfirst.org**.

Women 16–24 years old identified as sexually active should be screened annually for chlamydia.

# Mental Illness and Substance Abuse — Best Practices

Behavioral health and substance abuse disorders (SUD) affect a substantial portion of the U.S. population. Nearly half of all Americans will develop a mental illness during their lifetime[1]. One in four Americans (approximately 61.5 million) experiences a mental illness or substance abuse disorder each year, and the majority also has a comorbid physical health condition[2]. According to the National Institute of Mental Health, in 2014 there were an estimated 43.6 million adults age 18 or older in the United States with some form of mental illness. Adults living with serious mental illness (SMI) die on average 25 years earlier than other Americans, largely due to treatable medical conditions[3].

One in four Americans (approximately 61.5 million) experiences a mental illness or substance abuse disorder each year, and the majority also has a comorbid physical health condition[2].

Universal screening is the best way to ensure that our members' mental-health needs are holistically addressed. As a Healthfirst provider, we encourage you to utilize the following screening and brief assessment tools in your primary care practices to assist in stratifying the severity and intensity of your patients' mental illness or substance abuse disorder and intervene appropriately:

- **Depression —** PHQ-2 and PHQ-9 are multipurpose instruments for screening, diagnosing, monitoring, and measuring the severity of depression. They incorporate the DSM-IV diagnostic criteria in a brief self-report tool — **www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf**.
- **Anxiety —** Generalized Anxiety Disorder is a seven-question screening tool that identifies whether a complete assessment for anxiety is indicated — **www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf**.
- **Brief Screening Instrument for Adolescent Tobacco, Alcohol, and Drug Use —** BSTAD is a screening tool for use in pediatric settings, identifying adolescents with substance use — **www.ncbi.nlm.nih.gov/pmc/articles/PMC4006430**.

- **Alcohol Use —** The AUDIT-C is a three-item alcohol screening to assist in identification of patients who have alcohol use disorders or who are drinking hazardously. Scored on a scale of 0–12, each question has five answer choices. In men, a score of four or more is considered positive; in women, that score is three or more. The screening instrument and scoring chart can be found here — **www.integration.samhsa.gov/images/res/tool_auditc.pdf**.
- **Substance Use Disorders —** The DAST-10 (Drug Abuse Screen Test) is a 10-item, yes/no, self-report instrument that has been condensed from the 28-item DAST and should take less than eight minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. The tool and more information about it can be found here — **www.integration.samhsa.gov/images/res/tool_auditc.pdf**.

In addition, please reference the **Numerator Requirement** for each Healthcare Effectiveness Data and Information Set (HEDIS) measure below. They represent the clinical guidelines recommended by the National Committee for Quality Assurance (NCQA). You can also visit our website at **www.healthfirst.org** to access more information, clinical tools, and resources on behavioral health and substance abuse.

| Code | Measure Name | Age Band | Denominator Event | Numerator Requirement | Line of Business (LOB) |
|---|---|---|---|---|---|
| ADD | Follow-up Care for Children Prescribed ADHD Medication | 6–12 | Children with newly prescribed medication for attention-deficit/ hyperactivity disorder (ADHD) | Need at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:<br>1. **Initiation Phase:** The percentage of members with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.<br>2. **Continuation and Maintenance Phase:** The percentage of members with an ambulatory prescription dispensed for ADHD medication that remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. | Medicaid<br>HARP<br>QHP<br>EP |
| AMM | Antidepressant Medication Management | 18+ | Members who:<br>■ were treated with antidepressant medication, **and**<br>■ had a diagnosis of major depression, **and**<br>■ remained on an antidepressant medication treatment | Two rates are reported:<br>1. **Effective Acute Phase Treatment:** The percentage of members that remained on an antidepressant medication for at least 84 days (12 weeks)<br>2. **Effective Continuation Phase Treatment:** The percentage of members that remained on an antidepressant medication for at least 180 days (6 months) | Medicaid<br>HARP<br>QHP<br>EP<br>Medicare |

*Continued on pg. 46*

## Mental Illness and Substance Abuse — Best Practices

*Continued from pg. 45*

| Code | Measure Name | Age Band | Denominator Event | Numerator Requirement | Line of Business (LOB) |
|---|---|---|---|---|---|
| APM | Metabolic Monitoring for Children and Adolescents on Antipsychotics | 1–17 | Members who were on two or more antipsychotic prescriptions | Had both of the following during the measurement year:<br>■ At least one test for blood glucose or HbA1c<br>■ At least one test for LDL-C or cholesterol | Medicaid<br>HARP<br>EP |
| APP | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics | 1–17 | Members who had a new prescription for an antipsychotic medication during the measurement year | Documentation of psychosocial care with or without a telehealth modifier in the 121-day period from 90 days prior to the diagnosis date through 30 days after the diagnosis date. | Medicaid<br>HARP<br>EP |
| FUA | Follow-up After Emergency Visit for Alcohol and Other Drug Abuse or Dependence | 13+ | Members who had an emergency department (ED) visit for a diagnosis of alcohol or other drug (AOD) dependence. The denominator for this measure is based on ED visits, not members. If members have more than one ED visit for AOD, all ED visits on or between January 1 and December 1 (no more than one visit per 31-day period) in the measurement year will be included | Had a follow-up outpatient visit, telephone visit, or online assessment with any practitioner. Two rates are reported:<br>1. The percentage of ED visits that resulted in a follow-up within 30 days of ED visit<br>2. The percentage of ED visits that resulted in a follow-up within seven days of ED visit. | Medicaid<br>HARP<br>EP<br>Medicare |
| FUH | Follow-up After Hospitalization for Mental Illness | 6+ | Members who were hospitalized for treatment of selected mental illness diagnoses | Had a follow-up outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner after discharge. Two rates are reported:<br>1. The percentage of members who received follow-up within 30 days of discharge<br>2. The percentage of members who received follow-up within seven days of discharge. | Medicaid<br>HARP<br>QHP<br>EP<br>Medicare |
| FUM | Follow-up After Emergency Visit for Mental Illness | 6+ | Members who had an emergency department (ED) visit for a diagnosis of mental illness. The denominator for this measure is based on ED visits, not members. If members have more than one ED visit for mental illness, all ED visits on or between January 1 and December 1 (no more than one visit per 31-day period) in the measurement year will be included | Had a follow-up outpatient visit, telephone visit, or online assessment with any practitioner. Two rates are reported:<br>1. The percentage of ED visits that resulted in a follow-up within 30 days of ED visit<br>2. The percentage of ED visits that resulted in a follow-up within seven days of ED visit | Medicaid<br>HARP<br>EP<br>Medicare |

| Code | Measure Name | Age Band | Denominator Event | Numerator Requirement | Line of Business (LOB) |
|---|---|---|---|---|---|
| IET | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | 13+ | Adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence | Two rates are reported:<br>1. **Initiation of AOD Treatment:** The percentage of members that initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis<br>2. **Engagement of AOD Treatment:** The percentage of members that initiated treatment and that had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit | Medicaid HARP QHP EP Medicare |
| SAA | Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 19–64 | Members with schizophrenia | Dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. | Medicaid HARP |
| SMC | Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia | 18–64 | Members with schizophrenia **and** cardiovascular disease | Had an LDL-C test during the measurement year. | Medicaid HARP |
| SMD | Diabetes Monitoring for People with Diabetes and Schizophrenia | 18–64 | Members with schizophrenia **and** diabetes | Need both:<br>■ an LDL-C test and<br>■ an HbA1c test during the measurement year | Medicaid HARP |
| SSD | Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications | 18–64 | Members with schizophrenia or bipolar disorder and were dispensed an antipsychotic medication | Had a glucose screening test or an HbA1c screening test during the measurement year. | Medicaid HARP |

Sources:

[1]Kessler, RC, et al. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Cormorbidity Survey Replication. Archives of General Psychiatry, 62, 593–602.

[2]Kessler, RC, et al. (2005). Prevalence, Severity and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62, 617–627.

[3]Parks, J, et al. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

# Network Updates

## Healthfirst Bronze Pro EPO and Healthfirst Bronze Pro Plus EPO and Health Savings Accounts

Members of Healthfirst Bronze Pro EPO and Healthfirst Bronze Pro Plus EPO plans can save money on healthcare expenses and lower their tax liability with tax-free contributions to their Health Savings Account (HSA).* In addition, Healthfirst is the only carrier in the market that covers all HSA administrative costs typically applied to employers and members.

For more information about Healthfirst's HSA options, visit **HealthEquity.com**.

*Available only to members of Healthfirst's 2018 Bronze Pro EPO plan and 2018 Bronze Pro Plus EPO plan.

## Coverage Determinations and Prior Authorizations

**Your timely response will help your patients get the prescriptions they need to stay healthy.**

When you prescribe medications to your patients, there are times when Healthfirst and our pharmacy benefits manager, CVS Caremark, may need more information—for example, when the medication is not on our formulary or requires a prior authorization. In these instances, CVS Caremark will try to contact you at least three times, by telephone and/or by fax, for more information. **It's critical that you respond to these requests within the timeframes below, otherwise the prescription will be denied and your patient will be responsible for the full cost of the medication.**

Please be mindful of the following timeframes when you receive requests for information so your patients can get the medications they need:

- **Prior Authorization/Coverage Determinations**
  Healthfirst must provide a decision within 72 hours of the initial prescription request (expedited requests: 24 hours).
- **Appeal of Prior Authorization/Coverage Determinations**
  Healthfirst must provide a decision within seven calendar days of an appeal request (expedited requests: 72 hours).

As always, be sure to check the formulary associated with your patient's plan to avoid prescribing a medication we don't cover.

If you have any questions or concerns, please contact CVS Caremark at **1-855-344-0930**, Monday to Friday, 8am–10pm; Saturday, 8am–5pm.

As always, be sure to check the formulary associated with your patient's plan to avoid prescribing a medication we don't cover.

## New Medicare Cards

The Centers for Medicare & Medicaid Services (CMS) is partnering with the Social Security Administration (SSA) to remove Social Security numbers from Medicare ID cards. The purpose of this initiative is to prevent fraud, fight identity theft, and protect the private healthcare and financial information of Medicare beneficiaries.

In April 2018 the SSA began issuing the new Medicare ID cards with a new, unique, randomly assigned eleven (11)-character number, called a Medicare Beneficiary Identifier (MBI), to replace the existing Social Security number-based Health Insurance Claim Number (HICN), both on the Medicare cards and in various CMS and SSA systems. *New York residents began receiving their new Medicare cards in June 2018.*

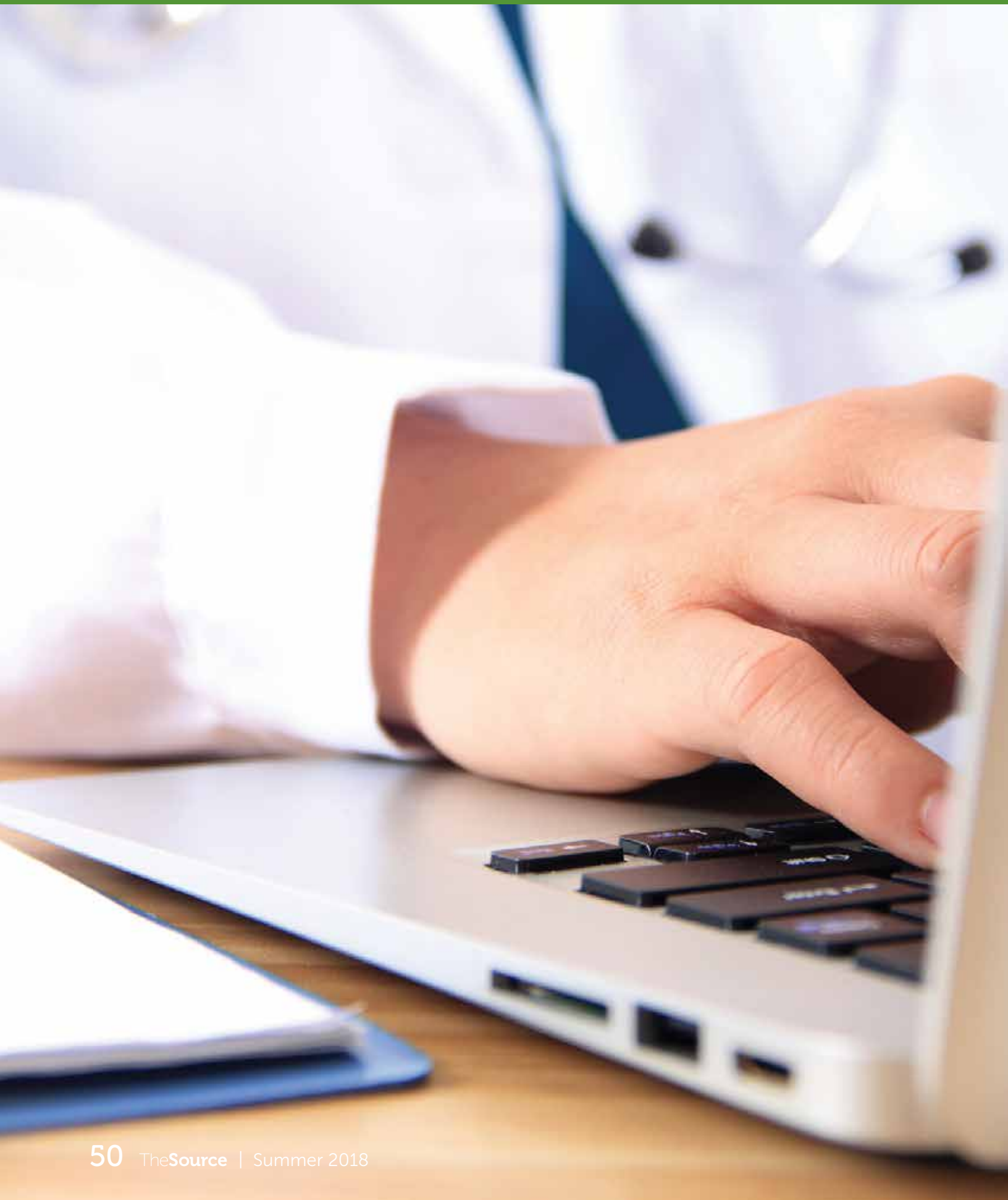
By April 2019, SSA will have replaced all Medicare cards.

This CMS initiative impacts any New York Healthfirst member eligible for Medicare, Medicaid Advantage Plus, or FIDA (Medicare-Medicaid).

**CMS suggests that providers verify the addresses of the Medicare and FIDA patients.** If the addresses you have on file are different, ask your patients to contact the Social Security Administration at **1-800-772-1213** (TTY 1-800-325-0778), Monday to Friday, 7am–7pm, and update their office records.

Although CMS is facilitating this change, Healthfirst members will continue to use their Healthfirst ID card when presenting for services at your office or facility. The Healthfirst ID card and number will not be impacted. Therefore you should continue to submit claims to Healthfirst using the individual member's Healthfirst ID number. To make this change easier for you and your business operations, CMS has established a 21-month transition period where all healthcare providers will be able to use either the MBI or the HICN to bill Fee-for-Service or Original Medicare during the transition period.

**Note:** You can continue to bill Healthfirst using the Healthfirst Member ID number.



# Online Resources for Your Practice

| | |
|---|---|
| www.HFprovidermanual.org | Review and download the most current Provider Manual. |
| www.healthfirst.org/QRGs | **Quick Reference Guides (QRGs)** for all our products to help you easily access valuable information. |
| www.healthfirst.org/alerts | Alerts and communications to make sure you have the information you need to offer our members top-quality care. |
| www.healthfirst.org/providerforms | Authorization and request forms in one location. |
| www.HFDocFinder.org | **Online provider directory** gives you and your patients detailed provider information—including weekend hours, office locations, and hospital affiliation—in an easy-to-use navigation.<br>Review and update your provider profile and practice information. |
| www.HFNewProviders.org | Access to orientation materials, everyday resources to provide the best possible care, in-depth product information, and more. |

WEB

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