

# MetroMonitor

Provider Newsletter

Summer 2009

## MetroPlus Member Retention

Each month, members enrolled in Child Health Plus (CHP), Family Health Plus (FHP) and Medicaid (MA) are involuntarily disenrolled

from Metro Plus Health Plan because they failed to renew their coverage. The MetroPlus Member Retention department works throughout the year to ensure

it reaches as many members as possible and works with them to

complete the renewal process.

The Member Retention department uses a three-pronged strategy: Outreach, Education, and Assistance to help members with the application process.

Providers can also play an important

role in helping members renew their coverage. For a provider, it pays to have patients who continuously have coverage as it promotes continuity of care and promotes the cost-effective, high-quality care providers strive to provide. Ensuring your patients have coverage is also imperative for ensuring the receipt of payment for services provided.

The recertification process differs between CHP and FHP/MA. Our Member Retention department can assist your patients with their annual renewal process. For more information, or to speak to a Member Retention representative, please call our in house support at (212) 908-3729 (Dulce Thomas) or (212) 908-3611 (Doris Delarosa).



### ✓ Reminders

#### ✓ MetroPlus Compliance Hotline

MetroPlus has launched our own Compliance Hotline, 1-888-245-7247. You may call this line to report fraud or abuse, illegal activities, and questionable activity. You may choose to give your name or you may report anonymously.

#### ✓ Medicaid Enrollees Cannot Be Billed

As a participating provider in the New York State Medicaid program, you are prohibited from requesting any compensation from the enrollee, or his/her relative, except for any applicable Medicaid co-payments unless there is a private pay arrangement. To avoid

the risk of not receiving payment, always check a member's eligibility before each service. To check eligibility, use the fax recall system (1-800-303-9626), or online at <https://public.metroplus.org> or <https://www.emedny.org/epaces>.



Receive the MetroMonitor by Email: Send your email address to [carnee@nychhc.org](mailto:carnee@nychhc.org)

## Message from the Chief Medical Officer

I am pleased to inform you that MetroPlus Health Plan and Maimonides Medical Center in Brooklyn have reached an agreement on a new contract. Under the new agreement, MetroPlus members will continue to have access to Maimonides Medical Center for hospital and specialty care services.

We are very happy to be able to continue our partnership with Maimonides and look forward to having them continue to provide quality services to our members.

No action is required by MetroPlus members to continue services at Maimonides. They can continue to receive specialty and outpatient services at Maimonides without an authorization.

If you have any questions, you may contact your Network Relations Representative or call MetroPlus at 1-800-303-9626. You may also visit our website at [www.metroplus.org](http://www.metroplus.org) for additional information.



Van Dunn, MD, MPH, FACP  
Chief Medical Officer

## Office Based Surgery Accreditation: Deadline July 14, 2009

Please be aware of a recent change to MetroPlus Health Plan's Credentialing procedures regarding accreditation requirements for office-based surgery. Please note the following change:



Providers seeking credentialing privileges for surgical or other invasive procedures performed in outpatient settings and under moderate sedation, deep sedation or under general anesthesia are ineligible unless accreditation for such procedures has been granted by The Joint Commission, the American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF), and the Accreditation Association for Ambulatory Health Care (AAAHC).

As of July 14, 2009 the New York State Department of Health requires the accreditation of such practices in which physicians, physician assistants or specialist

assistants (providers) perform office based-surgery, and requires the reporting of certain adverse events. A provider who fails to practice in an accredited setting after July 14, 2009 may be guilty of professional misconduct. Additionally, this law is specific to physicians and does not cover procedures performed by dentists and podiatrists who are not regulated by the New York State Department of Health.

Additional information regarding this legislation can found on the New York State Department of Health's website at [www.nyhealth.gov/professionals/office-based\\_surgery](http://www.nyhealth.gov/professionals/office-based_surgery).

## Telephonic and After Hours Access Standards for PCPs and Par OB/Gyns

All MetroPlus PCPs and Participating OB/Gyns are responsible for ensuring that MetroPlus members have access to services twenty-four hours per day, seven days per week. The provider's office must provide a working telephone number for members to access during normal business hours.

If you treat members who do not have the ability to receive a return call, you must make accommodations for them. If you have a live voice answering service, the answering service should instruct members that cannot receive a return call to remain on the telephone while the service attempts to reach you. If this service is not available,

MetroPlus providers must establish alternative arrangements.

All MetroPlus providers must be on-call or designate another participating MetroPlus provider to provide on-call coverage to respond to member concerns after hours, on weekends, and during short and long term leaves of absence. On-call providers are required to return all phone calls within thirty minutes. Additionally, all providers must provide MetroPlus with an after hours contact number at which a live person can be reached. If your office phone is answered by an answering machine the message must refer members to a phone number

answered by a person able to make a direct connection or alternative arrangements. Answering machines may also refer calls to the MetroPlus 24-hour Healthcare Hotline whose agents can contact the provider or make alternative arrangements.



By Teodor Todhe, MPA

The diagnosis and management of depression in the primary care setting is important not only to alleviate the mental anguish experienced by patients but also to improve adherence to primary care visits, increase medication compliance and assist in the management of other co-morbid conditions.

### Screening for Depression

There are many screening tools available to assist primary care providers elicit the symptoms and signs suggestive of depression. The US Preventive Services Task Force suggests asking two simple questions about mood and anhedonia (“Over the past 2 weeks, have you felt down, depressed, or hopeless?” and “Over the past 2 weeks, have you felt little interest or pleasure in doing things?”) may be as effective as longer screening instruments.

### Treatment Options

Antidepressants, psychotherapy, or the combination of both are the three options for the initial management of major depression. Usually, the “first-line treatment” is either antidepressant medication or psychotherapy. The combination of both is recommended in patients with severe or chronic depression.

Based on their site of action, antidepressants are classified as:

- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Tricyclic Antidepressants (TCAs)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- Norepinephrine Reuptake Inhibitors (NRIs)
- Dopamine Agonists (DAs)

The “second-line treatment” options should be considered in all cases who fail to gain

remission after the first line treatment. These options include:

- Combining antidepressants with psychotherapy
- Increasing the dose of the initial antidepressant
- Switching to a different antidepressant of the same or different class
- Combination of antidepressants from two different classes
- Low dose increase of lithium

Second line treatments often require collaboration and co-management with a psychiatrist.

### Managing Patients with Suicidal Ideation

Providers should routinely screen patients for suicidal ideations/intentions searching for the following signs:

- Presence of suicidal or homicidal ideation, intent, or plans
- Access to means for suicide and the lethality of those means
- Presence of psychotic symptoms, command hallucinations, or severe anxiety
- Presence of alcohol or substance use
- History and seriousness of previous attempts
- Family history of or recent exposure to suicide

Patients expressing suicidal behavior should be referred to a psychiatrist or psychiatric ER.

### Monitoring Patients with Depression

It is important to conduct follow up visits to assess a patient’s response to treatment, check for side effects, assess patient adherence to treatment regimens, and initiate, if the situation warrants, a referral to a psychiatrist. During the acute phase (the first 3 months) patients should be seen at least twice. The first visit or contact must be within the first month after the start of medication and, ideally, the second visit no later than 4 to 8 weeks after that.

Patients in remission during the continuation phase (up to 12 months after diagnosis) should be seen during the 5th to 6th month

after the start of treatment and around the 12th month into treatment, the time when a provider might plan or consider the discontinuation of treatment. At least one annual follow up visit is recommended for asymptomatic patients that are on antidepressants beyond 12 months after the initiation of treatment for depression.

### Length of Treatment

Based on acuity of depression, evidence based guidelines recommend:

- In patients with first episode of major depression, providers may consider the discontinuation of antidepressants only if the patient has been in remission and symptom free for at least 6 to 12 months after acute phase treatment.
- Patients with two or more lifetime episodes of major depression who are in remission after the acute phase should be continued on the same medication and dose with which remission was achieved for at least an additional 15 months to five years after acute phase treatment.

When considering discontinuation, it should be borne in mind that most antidepressants require tapering over a 2 to 4 week period.

### MetroPlus Health Plan’s Quality Improvement Project

MetroPlus Health Plan considers the diagnosis and management of depression an important aspect of medical care and crucial to the mental and physical wellbeing of our members. A Quality Improvement Project (QIP) to improve clinical outcomes of members with major depressive disorder is underway. The data derived from the QIP will be shared with providers and we hope assist our members adhere to their depression treatment plans. Members and providers can access the services of our Behavioral Health Disease Management program at 1-800-579-9798. MetroPlus adopts the HEDIS/QARR indicator “Antidepressant Medication Management” indicator, which stipulates that members older than 18 years old diagnosed with a new episode of major depressive disorder should be on continuous treatment for at least six months.



## Benefit Changes

**Smoking Cessation:** Effective January 1, 2009, Medicaid will reimburse office based providers and hospital outpatient departments for smoking cessation counseling. Reimbursement for these services will be available to free-standing diagnostic and treatment centers effective March 1, 2009. This counseling will complement existing Medicaid covered benefits for smoking cessation coverage, which include prescription and nonprescription smoking cessation products. Note: A Federally Qualified Health Center (FQHC) may bill for this service ONLY if it has elected to be reimbursed under Ambulatory Patient Groups (APGs). Medicaid managed care and Family Health Plus plans are also responsible for covering smoking cessation counseling services for pregnant women since January 1, 2009. Coverage includes up to six counseling sessions within any 12 month period.

**Asthma & Diabetes:** NYS Medicaid will cover diabetes and asthma self management training services (DSMT and ASMT, respectively) for Medicaid

beneficiaries diagnosed with diabetes or asthma when such services are ordered by a physician, registered physician's assistant (PA), registered nurse practitioner (RNP), or a licensed midwife (LM). This change will become effective in physicians' offices and hospital outpatient departments

(OPDs) on January 1, 2009, and in free-standing diagnostic and treatment centers (D&TCs) on March 1, 2009. Note: A Federally Qualified Health Center (FQHC) may bill for this service ONLY if it has elected to be reimbursed under Ambulatory Patient Groups (APGs).



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