

MetroMonitor

Provider Newsletter

March 2010

Prevention and Management of Pediatric Obesity

MetroPlus Health Plan supports the Childhood Obesity Recommendations from the National

Initiative for Children's Healthcare Quality (NICHQ), proposing that Practitioners adopt an obesity plan for children. The recommendations in the five point obesity prevention plan may assist in preventing childhood obesity as well as emphasize:

- Breastfeeding;
- BMI;
- Less than two hours of screen time daily;
- More than one hour of daily physical activity;
- Zero sugar sweetened beverages.

BMI Tools Available

For children and adolescents ages 2 to 19, you must also plot their BMI on growth charts to determine a BMI percentile ranking, since norms vary with age and gender. Tools can be found at:

- www.health.state.ny.us/prevention/obesity/bmi_screening_tools.htm
- www.pediatrics.about.com

The Childhood Obesity Action Network, formed under NICHQ has published an implementation guide to help practitioners improve and manage Childhood Obesity. The implementation guide is available at: www.nichq.org.



✓ Reminders

✓ **MetroPlus Compliance Hotline**
MetroPlus has its 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.

✓ **MetroPlus Ranked #1**
MetroPlus is pleased to announce that the NYS Dept of Health

(DOH) ranked MetroPlus #1 in quality and member satisfaction in the *Consumer's Guide to Medicaid Managed Care in New York City*.

✓ **Clinical Practice Guidelines**
MetroPlus encourages the use of Clinical Practice Guidelines for the provision of acute, chronic, screening and behavioral health services that are relevant to our members. All

Clinical Practice Guidelines are evidence based, reviewed annually by our Quality Assurance Committee, and updated as appropriate. The guidelines can be accessed at www.Metroplus.org. If you would prefer a paper copy of a specific Clinical Practice Guideline please call Customer Services at 1-800-303-9626.



Receive the MetroMonitor by Email: Send your email address to carnee@nychhc.org

Message from the Chief Medical Officer

Each year MetroPlus conducts a provider satisfaction survey to gauge your level of satisfaction with the service that MetroPlus provides. We are pleased to announce the outcome from the 2009 survey. Our results tell us that when compared to all other health plans in the market, your overall satisfaction with MetroPlus is very high. The overall satisfaction question is a combination of questions that asks you to rate your overall satisfaction with MetroPlus Health Plan as compared to all other plans in which you participate, and whether you are likely to recommend MetroPlus Health Plan to other providers. MetroPlus was also rated excellent or very good in the following areas: Customer Service, Provider Services, Provider Network, Finance, Utilization Management, Care Management and Quality Management. We look forward to continuing a working partnership that will improve the level of service we provide to our members.



Van Dunn, MD, MPH, FACP
Chief Medical Officer

Patient-Centered Medical Home Incentive Program

Chapter 58 of the Laws of 2009 authorized the New York State Department of Health to implement an initiative to promote the development of patient-centered medical homes for Medicaid members receiving primary care services with the aim of improving health outcomes through better coordination and integration of patient care. Upon federal approval, office-based practitioners (physicians and registered

nurse practitioners) and Article 28 clinics recognized by the National Committee for Quality Assurance (NCQA) Physician-Practice Connections – Patient Centered Medical Home Program (PPC®-PCMH™) will receive additional payment for primary care services provided to Medicaid beneficiaries. The enhanced payment will be associated with the provider's or clinic's NPI and will be paid through eMedNY

for Medicaid fee-for-service patients and by health plans for those enrolled in Medicaid Managed Care or Family Health Plus. For more information, including reimbursement rates, please visit: www.nyhealth.gov/health_care/medicaid/program/update/2009/2009-12spec.htm

Vaccines for Children Immunization Program

The New York State Department of Health (NYSDOH) mandates participating practitioners enroll in the Vaccines for Children (VFC) program if they serve Medicaid Managed Care and Child Health Plus members. VFC is a federally funded program that supplies free vaccines to children under 19 years of age who are uninsured, under-insured, Native-American or who receive health care through fee-for-service Medicaid, a Medicaid

Managed Care Plan (MMCP), or Child Health Plus.

MetroPlus Health Plan does not reimburse for the cost of vaccines administered to children enrolled in Medicaid or Child Health Plus programs. Participating practitioners must enroll in the VFC program to obtain vaccines free of charge for these populations. The Plan does reimburse the administration fee for each vaccine your office provides. If you are not enrolled in the VFC program, please enroll now. New York City practitioners may call the VFC Immunization Program at 1-212-447-8175. Once enrolled, you learn how to order vaccines through the program and vaccine deliveries arrive within 3-5 business days. Remember, practitioners are responsible for tracking and reporting vaccines administered to all members under the age of

19 to the NYS Immunization Information System (NYSIIS).

For more information, please contact NYSIIS at 1-518-473-4437 or by e-mail at: nysiis@health.state.ny.us. You can also go to the NYSIIS Web site at: www.health.state.ny.us/prevention/immunization/information_system. New York City practitioners may report to the Citywide Immunization Registry (CIR) at www.nyc.gov/html/doh/html/cir. For additional information, please call 1-212-676-2323.

The federal government will pay for the H1N1 flu vaccine and MetroPlus Health Plan will cover seasonal flu and H1N1 flu vaccine administration for plan members. All children aged 19 years and under are covered regardless of vaccine benefit coverage. To register to receive the H1N1 Vaccine please go to: <https://hcsteamwork1.health.state.ny.us/pub/toph1n1.html>.



MetroPlus and LabCorp Expand Partnership



MetroPlus is pleased to announce that Laboratory Corporation of America Holdings (LabCorp) has been designated as the exclusive national laboratory provider for outpatient laboratory services for members of MetroPlus effective February 15, 2010. MetroPlus providers may continue to utilize other MetroPlus participating regional and hospital based laboratories - they remain par and can continue to service our members.

MetroPlus providers are required to refer members to participating laboratories for testing. Quest Diagnostics Laboratories is not participating in the MetroPlus network.

If you would like to set up an account with LabCorp, you can call 888-295-5915 to speak with a representative about setting up an account or request on NENewAccounts@labcorp.com. If you draw specimens in your office, the representative can also arrange a collection schedule to meet your needs. If you have any questions regarding MetroPlus policy, please contact your MetroPlus Provider Relations Representative, or call Provider Services at 1-800-475-6387. You can also visit www.metroplus.org for more information.

Managed Care Legislation Notifications

The following summarizes the various changes to New York State Insurance Law and Public Health Law which were enacted as a part of the Chapter 237 of the Laws 2009. MetroPlus is updating its policies and procedures to reflect these changes and will include them in an updated Provider Manual, which will be made available later this year.

Change in Fee Schedule Reductions

Health care professionals are to receive written notice from the MCO at least 90 days prior to an adverse reimbursement change to the provider's contract. If the health care professional objects to the change that is the subject of the notice by the MCO, the health care professional may, within thirty days of the date of the notice, give written notice to the MCO to terminate the contract effective upon the implementation of the adverse reimbursement change. An adverse reimbursement change is one that "could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional". A health care professional under this section is one who is licensed, registered or certified under Title 8 of the New York State Education Law.

Change in Prompt Pay

Claims submitted electronically must be paid within 30 days and paper or facsimile

claim submissions must be paid within 45 days. The 30 day timeframe for requesting additional information of for denying the claim was not changed.

Timely Filing Reconsideration

Section 3224-a (h) of the insurance law permits a reconsideration of a participating provider's late claim submission denied exclusively because it was untimely. Where the provider can demonstrate that the late claim resulted from an unusual occurrence and the provider has a pattern of timely claims submissions the MCO must pay the claim. However, the MCO may reduce the reimbursement of a claim by up to 25 percent of the amount that would have been paid had the claim been submitted in a timely manner. Nothing precludes an MCO and a provider from agreeing to a reduction of less than 25 percent. The right to reconsideration shall not apply to a claim submitted 365 days after the service and in such cases the MCO may deny the claim in full. *MetroPlus considers an unusual occurrence to be the result of actions or events that are unforeseeable and for which planning could not have been possible. The following is a list of circumstances MetroPlus would not honor as meeting the definition of an unusual occurrence: 1) Rejections of EDI claim submissions, 2) Provider office relocations, 3) Changes in billing agents. This list is meant to be illustrative and is not all inclusive.*

Changes in Overpayment Recoupment

The process for overpayment recoveries in section 3224-b (b) of the insurance law was amended to apply to all health care professionals licenses, registered, or certified under Title 8 of the State Education Law, and providers licensed or certified pursuant to PHL Articles 28, 36 or 40 or Mental Hygiene Law Articles 19, 31 and 32. The statute requires that MCOs provide the health care professional or provider with an opportunity to challenge the overpayment recovery.

Clarification in Participating Providers

MCOs are prohibited from treating a claim from a network hospital as out-of-network solely on the basis that a non-participating health care provider treated the member. Likewise, a claim from a participating health care provider cannot be treated as out-of-network solely because the hospital is non-participating with the MCO. Health care provider in this section means an individual licensed, certified or registered under Title 8 of the Education Law or comparably licensed, registered or certified by another state.

Hold Harmless

Public Health Law was amended to add a new section 4917. A provider requesting an external appeal of a concurrent adverse

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determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable co-pays, from a member for services determined not medically necessary by the external appeal agent.

Costs of External Review

Payment for an external appeal at Public Health Law section 4914 was amended to include a health care provider filing an external appeal of a concurrent adverse determination. A provider will be

responsible for the full cost of an appeal for a concurrent adverse determination upheld in the favor of the MCO; an MCO is responsible for the full cost of an appeal that is overturned; and the provider and MCO must evenly divide the cost of a concurrent adverse determination that is overturned in-part. The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of the MCO. For the provider to claim that the appeal of the final adverse determination is made

on behalf of the member will require completion of the external appeal application and the designation. The superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provisions described above. If the provider is unresponsive, the appeal will be rejected.

MetroPlus Member Retention

With the cold and flu season upon us, MetroPlus wants to help you keep your patients insurance coverage up to date. Each month, members enrolled in Child Health Plus (CHP), Family Health Plus (FHP) and Medicaid (MA) are involuntarily disenrolled from Metro Plus because they failed to renew their coverage. The MetroPlus Member Retention department works with these members throughout the year to help them complete the renewal process.

Providers can also play an important role in helping members renew their coverage. The recertification process differs between CHP and FHP/MA. Our Member

Retention department can assist your patients with their annual renewal process. You can also reach out to us for assistance with the new on-line MA/FHP recertification process. Additionally, contact us to take advantage of having a recertification representative set up an organized retention blitz at your office to assist your patients with recertifying while attracting new clientele for your practice.

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).



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