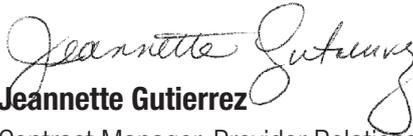




Welcome to the fall issue of Advantage, our newsletter for ArchCare Advantage network providers. This edition includes the latest information about ArchCare Advantage HMO Special Needs Plan and looks at new programs and tools for members, the risks of rising demand for powered mobility devices and ArchCare's 2014 HEDIS quality targets.

We welcome your feedback. Please let us know what you think by dropping a note to Advantage Provider News, 33 Irving Place, 11th Floor, New York, NY 10003. Or email us at [AAProviderServices@archcare.org](mailto:AAProviderServices@archcare.org).

As always, thank you for your continued dedication to ArchCare Advantage and our members.

  
**Jeannette Gutierrez**  
Contract Manager, Provider Relations

## NEW PROGRAMS AND TOOLS AID ADVANTAGE MEMBERS

ArchCare is working hard to ease members' burdens and simplify the lives of the people who care about them. To do so, we recently redesigned our website to be more user-friendly, launched a care navigation center to help consumers better understand their care options, built an online caregiver support system and introduced an innovative community service time bank.

### NEW AND IMPROVED ARCHCARE.ORG

Earlier this year, we revamped our website at [archcare.org](http://archcare.org) to make finding information about our services faster and easier. Our new Care Finder tool directs members and their loved ones to the available care options based on their location and the type of care required. The website is also the place for members to learn what's new at ArchCare and see the exciting activities taking place across our network.

### CARE NAVIGATION CENTER

Some managed care organizations do everything they can to make it difficult to speak to a real person. But not ArchCare. We think people deserve personal attention when making decisions as important as where to obtain care for themselves or a loved one. That's why our specially trained Care Navigators are available seven days a week to offer an understanding ear, answer questions and guide people to the care options that best meet their needs.

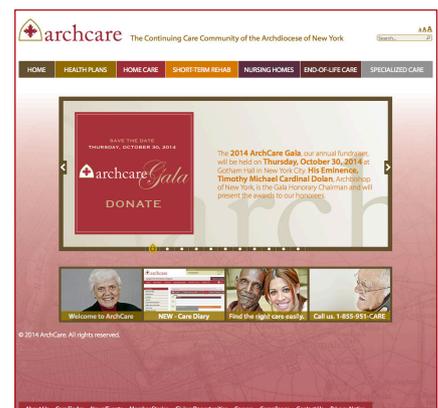
Your patients can reach our Care Navigators at 855-951-CARE (TTY/TDD: 711) seven days a week, from 8:00 a.m. to 8:00 p.m.

### CARE DIARY

At ArchCare, we consider family caregivers the unsung heroes of health-care. Supporting them and making their lives a little easier is the least we can do.

That's why we launched Care Diary, a free online support system designed to help them manage their loved one's care. Care Diary offers a host of useful tools, including:

- » An online calendar for coordinating medical and other appointments
- » Medication tracking
- » A journal to record important information like doctors' instructions
- » Storage for important healthcare documents
- » Personalized "circles" to keep relatives and friends informed



There is also a wealth of articles, videos and other timely content, as well as useful tips and information for family caregivers.

Please encourage your patients and their families to explore Care Diary and all it offers at [archcare.ecarediary.com](http://archcare.ecarediary.com).

### TIMEBANK

ArchCare TimeBank is a free service that connects individuals who need help with volunteers who have the time, energy and skills they need. Whether it's stopping in to provide companionship to a homebound elder, cutting the grass or doing other household chores for someone with a disability or even helping another member brush up on a foreign language or learn a new dance step, the TimeBank database has someone to fill virtually every need.

Learn more about TimeBank by calling (844) 880-4480, or emailing [timebank@archcare.org](mailto:timebank@archcare.org).

## CLAIMS CORNER

### CHANGES OF INFORMATION

Providers should submit a change of information request to add, delete or change any information we have associated with your current tax identification number(s). You must notify us within 30 days of any change.

To avoid returned payments for services, providers should take special care to keep their business addresses up to date.

To access the Provider Addition/Change Request form online, go to <https://www.archcare.org/health-plans/archcare-advantage/provider-manual>. Be sure to attach all required supporting documentation and submit your request to the address on the form.

### CHANGES IN THE CMS-1500 PAPER CLAIM FORMAT

A revised CMS-1500 claim form is available to facilitate ICD-10 compliance and fulfill other regulatory requirements for healthcare claims.

We recommend that providers submitting the CMS-1500 paper claim form use version 02/12, which may be required for paper claim submissions to ArchCare in the future. Important changes to the new CMS-1500 paper form include:

- » Indicators for differentiating between ICD-09-CM and ICD-10-CM diagnosis codes
- » Space for up to 12 diagnosis codes
- » Qualifiers for identifying, referring, ordering and supervising providers on item 17. The two-character qualifiers are:
  - DN - Referring Provider
  - DK - Ordering Provider
  - DQ - Supervising Provider

### REMINDER: ENCOUNTER DATA SUBMISSIONS REQUIRE HIPPS CODES

Skilled nursing facility and home health encounters must include HIPPS codes if available. Effective with dates of service on or after July 1, 2014, providers will be required to submit HIPPS codes in the UB-04 or 837 Institutional formats.

Encounters submitted without the appropriate HIPPS codes will be rejected.

If you have questions regarding your contract and billing obligations, contact your provider service representative at 800-373-3177 to review the terms of your agreement with ArchCare, your rates and your billing requirements.

## POWER MOBILITY DEVICES: WHO QUALIFIES?

Does it sometimes seem as though every other patient through your door asks for a prescription for a new power scooter? It should come as no surprise, given the constant stream of late-night TV ads promising viewers the latest and greatest Power Mobility Device (PMD) at absolutely no cost to them.

Providers beware. Writing a prescription for a PMD for somebody who doesn't qualify can bring severe consequences, including both criminal and civil penalties. Knowing who qualifies – and who doesn't – is the best way to steer clear of potential problems.

To meet the medical necessity requirements for a PMD, the patient MUST meet all three of the following criteria:

The patient must have a mobility limitation that significantly impairs his or her ability to participate in at least one Mobility-Related Activity of Daily Living, or MRADL. This mobility limitation must either:

Prevent the patient from completing the MRADL entirely or in a reasonable time; or,

Put the patient at a reasonably determined heightened risk of morbidity or mortality when performing the MRADL.

The mobility limitation cannot be resolved by a cane or walker; and,

The patient has insufficient upper extremity function to self-propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day.

Physical limitations, pain, deformity and missing extremities are relevant to the assessment of upper extremity function.

“Optimally configured wheelchair” means a wheelchair with an appropriate wheelbase, weight, seating option and non-powered accessories.



Additional criteria may apply to specific PMDs. Further guidance is available from Medicare at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD\\_DocCvg\\_FactSheet\\_ICN905063.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf).

### REPORT IT

Please do your part to prevent fraud by reporting suspected medical identity theft and other fraud, waste or abuse to your local law enforcement agency, your state Medicaid agency or your regional office of the U.S. Department of Health and Human Services. You can also report suspected fraud to ArchCare's Compliance Hotline at 800-443-0463, or to [ComplianceReport@archcare.org](mailto:ComplianceReport@archcare.org).

## IN-NETWORK REFERRALS CAN REDUCE PRACTICE WORKLOADS

In addition to our growing network of directly contracted providers, ArchCare Advantage members in the five boroughs of New York City and Dutchess, Orange, Putnam and Westchester counties are eligible for care through the EmblemHealth Medicare PPO network. Members in Onondaga County have access to Multiplan's Beech Street Network. We continue to add new providers every day to better serve our members and give them – and you – even more options.

Referring members to in-network providers whenever possible streamlines care for our members, lowers the risk of service denials and eases your office's administrative workload. Many services do not require authorization if performed by participating providers. To ensure quality, ArchCare Advantage also conducts background checks and reviews the professional credentials of all network members at the time of appointment, either directly or through credentialing agreements with our third-party networks. This is just another example of the lengths we go to for our members.

To access the ArchCare Advantage Provider Directory, go to [www.archcare.org](http://www.archcare.org) and click on the "Health Plans" tab. You can also call our Provider Relations Department at 800-373-3177 to check providers' network status. If you regularly refer patients to providers who are not in our network, please ask them to join, or tell us and we will be happy to reach out to them.

## MEDICATION THERAPY MANAGEMENT PROGRAM FOCUSES ON AT-RISK PATIENTS



The Centers for Medicare and Medicaid Services requires all Medicare Advantage and Part D prescription drug plans to offer Medication Therapy Management (MTM) programs. ArchCare's MTM program focuses on identifying members who are at risk for potential drug-related problems and helping them better understand the various drugs prescribed for them. The goal is to reduce drug-drug interactions and other risks, increase health awareness and help members achieve the maximum health benefit from their medications.

### WHO QUALIFIES FOR MTM?

Members who meet all three of the following criteria will automatically be enrolled in the MTM program at no cost:

The member takes eight or more Medicare Part D-covered maintenance drugs and has three or more of the following chronic health conditions: asthma, COPD, diabetes, depression, osteoporosis, chronic heart failure or cardiovascular disorders such as high blood pressure, high cholesterol or coronary artery disease; and,

The member reaches \$3,017 in yearly prescription drug costs, including costs paid by the plan. This will increase to \$3,138 in 2015.

Participation is voluntary and does not affect the member's coverage

in any way. The member may withdraw at any time and still remain a member of ArchCare Advantage. The MTM program is only open to those who qualify, and is not considered a benefit for all members.

### HOW DO MEMBERS KNOW IF THEY QUALIFY?

If a member qualifies, he or she will receive a letter with further details. The member may also receive a call from a partner pharmacy with an invitation to schedule a one-on-one medication review at a convenient time. If the member is unable to participate, the member's prescriber, caregiver or other authorized representative may do so on his or her behalf.

The MTM program pharmacist may be from the member's regular pharmacy if it has chosen to participate. Otherwise, the member will have the option of an in-person review at a participating pharmacy or a review by phone with one of our program pharmacists.

### WHAT SERVICES ARE INCLUDED IN THE MTM PROGRAM?

The MTM program includes a Comprehensive Medication Review (CMR) as well as a Targeted Medication Review (TMR).

The CMR is a one-on-one discussion between the member and a trained pharmacist to make sure the member's medications are safe and effective, answer questions and address any medication concerns relating to prescription drugs, over-the-counter medicines, herbal therapies, dietary supplements, vitamins and any other products the member may use. The pharmacist may also suggest ways to better manage their health conditions. If more information is needed, the pharmacist may contact the prescribing doctor.

The CMR takes about 30 minutes and is usually offered once each year if the member still qualifies. After the CMR, the pharmacist will provide the member with a list of the medications that were discussed and a Medication Action Plan suggesting topics to discuss with the doctor on the patient's next visit.

- continued on page 6 -

## ARCHCARE ADVANTAGE TARGETS HEDIS MEASURES FOR IMPROVEMENT

Every year, ArchCare Advantage is required to report the Healthcare Effectiveness Data and Information Set (HEDIS) to measure the quality of the care and service our members receive. As a Medicare Advantage Plan, we report a set of 41 measures across five domains of care. The Plan's performance in a set of measures selected by CMS is made available to the public through the Medicare Plan Finder. This year, we have targeted 11 specific areas for extra focus and improvement and are asking for our providers' help to make sure all ArchCare Advantage members in your care receive the following interventions before December 31, 2014.

Measure/ Indicator	Physicians/ Nurse Practitioners / Physician Assistants please insure ArchCare Advantage Members in your care receive the following interventions before December 31, 2014
<b>Colorectal Cancer Screening</b>	<p>Members 51-75 years of age should receive or have received a screening for colorectal cancer. Appropriate documentation in medical record for use during HEDIS. Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• Fecal occult blood test during the measurement year.</li> <li>• Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.</li> <li>• Colonoscopy during the measurement year or the nine years prior to the measurement year.</li> </ul> <p>Exclude members who have a dx of colorectal cancer or total colectomy performed anytime prior to December 31, 2014.</p>
<b>Breast Cancer Screening</b>	<p>Women 52-74 years of age as of December 31, 2014. One or more mammograms any time on or between October 1, 2012 and December 31, 2014. Exclusions: Bilateral mastectomy any time during the member's history through December 31, 2014.</p>
<b>Adult BMI Assessment</b>	<p>Members 18 years old as of January 1, 2013 to 74 years old as of December 31, 2014 should have a Body Mass Index (BMI) determination. Documentation in the medical record must indicate the weight and BMI value, dated during 2014, expressed as a percentage. The weight and BMI must be from the same data source.</p> <p>For members younger than 19 years on the date of service, the following documentation of BMI percentile also meets criteria:</p> <ul style="list-style-type: none"> <li>• BMI percentile documented as a value (e.g., 85th percentile).</li> <li>• BMI percentile plotted on an age-growth chart.</li> </ul> <p>Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance.</p>
<b>Care of Older Adults</b>	<p>Members 66 years and older as of December 31, 2014 will have the following four indicators performed.</p>
<b>1. Advance Care Planning</b>	<p>Members 66 years and older as of December 31, 2014, should have evidence of advance care planning during 2014. Advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end of life care. Evidence of advance care planning must include one of the following:</p> <ul style="list-style-type: none"> <li>• The presence of an advance care plan in the medical record.</li> <li>• Documentation of an advance care planning discussion with the provider and the date when it was discussed. The documentation of discussion must be noted during 2014.</li> <li>• Notation that the member previously executed an advance care plan.</li> </ul> <p>Examples of an advance care plan:</p> <ul style="list-style-type: none"> <li>• Advance directive. Directive about treatment preferences and the designation of a surrogate who can make medical decisions for a patient who is unable to make them (e.g., living will, power of attorney, health care proxy).</li> <li>• Actionable medical orders. Written instructions regarding initiating, continuing, withholding or withdrawing specific forms of life sustaining treatment (e.g., Physician Orders for Life Sustaining Treatment [POLST], Five Wishes).</li> <li>• Living will. Legal document denoting preferences for life-sustaining treatment and end-of-life care.</li> <li>• Surrogate decision maker. A written document designating someone other than the member to make future medical treatment choices.</li> </ul> <p>Administrative: Use of CPT II codes 1158F and 1157F</p>

<p><b>2. Pain Screening</b></p>	<p>Ensure at least one pain assessment is performed and contains the minimum medical record documentation elements required: Notation of a pain assessment must include one of the following: 1) Documentation the patient was assessed for pain (which may include +/- findings for pain) and date. 2) Results of assessment using a standardized pain assessment tool which may include but is not limited to: Numeric rating scales; Face, Legs, Activity, Cry Consolability (FLACC) scale; Verbal Description Scales (5-7 Word Scales, Present Pain Inventory); Pain Thermometer; Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale); Visual Analogue Scale; Brief Pain Inventory; Chronic Pain Grade; PROMIS Pain Intensity Scale; Pain Assessment in Advanced Dementia (PAINAD) Scale. The following documentation does not meet criteria: Notation of a pain management plan alone; Screening for chest pain alone; Documentation of chest pain alone.</p> <p>Administrative: Use of CPT II codes: 0521F, 1125F, 1126F is encouraged to reduce need for medical record review.</p>
<p><b>3. Medication Review</b></p>	<p>At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through either administrative data or medical record review. A medication list, signed and dated during the measurement year by the appropriate practitioner (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).</p> <p>Administrative: Use of CPT II and CPT codes for Medication Review: 1160F, 90862, 99605, 99606 and Medication List: 1159F: HCPCS G8427 is encouraged to minimize the need for medical record review.</p>
<p><b>4. Functional Status Assessment</b></p>	<p>Evidence of a complete functional status assessment and the date when it was performed. Notations for a complete functional status assessment must include one of the following:</p> <ul style="list-style-type: none"> <li>• Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.</li> <li>• Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.</li> <li>• Result of assessment using a standardized functional status assessment tool, not limited to: <ul style="list-style-type: none"> <li>– SF-36®</li> <li>– Assessment of Living Skills and Resources (ALSAR)</li> <li>– Barthel ADL Index Physical Self-Maintenance (ADLS) Scale</li> <li>– Bayer ADL (B-ADL) Scale</li> <li>– Barthel Index</li> <li>– Extended ADL (EADL) Scale</li> <li>– Independent Living Scale (ILS)</li> <li>– Katz Index of Independence in ADL</li> <li>– Kenny Self-Care Evaluation</li> <li>– Klein-Bell ADL Scale</li> <li>– Kohlman Evaluation of Living Skills (KELS)</li> <li>– Lawton &amp; Brody's IADL scales</li> <li>– Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales</li> </ul> </li> <li>• Notation that at least three of the following four components were assessed: <ul style="list-style-type: none"> <li>– Cognitive status</li> <li>– Ambulation status</li> <li>– Hearing, vision and speech (i.e., sensory ability)</li> <li>– Other functional independence (e.g., exercise, ability to perform job)</li> </ul> </li> </ul> <p>A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.</p> <p>Administrative : Use of CPT II code 1170F is encouraged to minimize the need for medical record review</p>

<b>Comprehensive Diabetes Care</b>	All members with a diagnosis of Type I or II Diabetes and who are 18-75 years of age as of December 31, 2014, must have the following tests performed before December 31, 2014:
<b>Hemoglobin A1c (HbA1c) Testing</b>	At least one Hemoglobin A1c performed during the measurement year. Documentation must include the date it was performed and the result.
<b>Eye Exam (Retinal) Performed</b>	An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: <ul style="list-style-type: none"> <li>• A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2014.</li> <li>• A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2013.</li> </ul>
<b>Blood Pressure Control</b>	One or more blood pressure readings during 2014.
<b>Medical Attention for Nephropathy</b>	Nephropathy screening test. At a minimum, documentation must include a note indicating the date when a urine microalbumin test was performed, and the result or finding. Any of the following meet the criteria for a urine microalbumin test: <ul style="list-style-type: none"> <li>• 24-hour urine for microalbumin.</li> <li>• Timed urine for microalbumin.</li> <li>• Spot urine for microalbumin.</li> <li>• Urine for microalbumin/creatinine ratio.</li> <li>• 24-hour urine for total protein.</li> <li>• Random urine for protein/creatinine ratio.</li> </ul>

## MEDICATION THERAPY MANAGEMENT PROGRAM FOCUSES ON AT-RISK PATIENTS

- continued from page 3 -

ArchCare Advantage conducts the TMR with the member's physician. The plan will mail or fax the physician every three months about medications that may be safer or more effective than those the member is currently taking. As always, the prescriber will decide whether to consider these suggestions. A member's prescription drugs will not change unless the member and doctor agree to change them.

### **HOW DOES THE REVIEW HELP THE PATIENT?**

Different doctors may write prescriptions without knowing all the prescription drugs and over-the-counter medications a member takes. The pharmacist can help the member better understand how various prescription and over-the-counter products may interact with one another and make them aware of any possible side effects. The review may also identify ways to reduce the member's prescription drug costs.

### **HOW CAN A MEMBER GET MORE INFORMATION ABOUT THE MTM PROGRAM?**

To find out more about the ArchCare Advantage Medication Therapy Management (MTM) program, members can call Customer Care toll free at 888-816-7977 (TTY 866-236-1069), 24 hours a day, 7 days a week.