Centers Plan for Healthy Living (CPHL) is excited to enter the 2017 spring season with a renwed focus on promoting preventive care and we invite you to join our efforts to ensure that all of our mutual Members: are appropriately immunized (i.e. receive their influenza and pneumococcal vaccines); receive appropriate mammography and colorectal cancer screening; receive appropriate dental, vision and hearing screenings; receive appropriate blood pressure screening; that our diabetic Members receive appropriate retinal screening, nephropathy screening, HBA1C follow-up; that our older adults (>65 years) have had advance care planning, medication reviews, functional status and pain assessments; that all of our Members who have experienced a recent hospitalization have had their medications reconciled within 30 days of discharge; and that our Members discharged after hospitalization for mental illness are seen in follow-up by their mental health provider within 7-days of discharge. This all begins with a visit to their Primary Care Provider – a visit that we encourage as early in the year as possible. CPHL's Care Managers stand ready to assist you and our Members to facilitate these visits.

CPHL is also continuing to build it's Provider base to support the delivery of quality care through its Managed Long Term Care (MLTC), Medicare Advantage (Advantage Care), Special Needs (Dual Coverage Care, Nursing Home Care) and FIDA Care Complete (Fully Integrated Dual Advantage) Plans. CPHL believes that a strong partnership with its Providers is essential to ensuring that our Members receive the highest level of quality care.

In furtherance of the above efforts, each year, CPHL submits data to the New York State Department of Health and the Centers for Medicare and Medicaid Services as part of a standardized process to develop consumer-focused Plan Ratings. These metrics ultimately reflect upon the quality of care that our MLTC, Medicare and FIDA Members received through their Providers over the prior year. Complete and accurate claims submissions, combined with appropriate medical record documentation, is critical for effectively capturing provided services for these reporting purposes. In this issue, we've provided some tips on ensuring that your claims are processed appropiately and reflect the care you are giving.

Thank you again for your commitment to our Members.

Sincerely,

Marco K. Michelson, MD

Marco K. Michelson
Chief Medical Officer

CLAIMS TO RELAY HEALTH

Please note that when submitting claims to Relay Health for processing, please make sure that the PLAN name "**Centers Plan for Healthy Living"** is on each claim. Many providers are sending claims to Relay Health, with "Relay Health" as the PLAN name which is incorrect. To reduce the number of claims that are returned, please make sure to follow the instructions below:

- o "**Centers Plan for Healthy Living**" should be located in Box 11C on a CMS 1500 Claim Form and Box 50 for a UB04 Claim Form.
- o Professional claims must have Box 32 (Location of Service) completed.
- o UB04 claims must have Box 2 completed when a Provider has multiple locations registered with Centers Plan.

All claims should be sent directly Relay Health's address for processing:
Relay Health, 1564 North East Expressway,
Mail Stop HQ2361-CPHL, Atlanta, GA 30329-2010.

If you have any questions regarding payments received, or on claims on which you have not received payments, please log in to PaySpan to download your remittance notice which spans the service dates in question:

- o Compare the remittance notice to the authorization you received;
- o Compare your claim submission to the authorization and remittance notice;
- o Reconcile all payments to claims that were submitted.

Please note that it is the provider's responsibility to reconcile claims and payments, and to follow up on any discrepancies according to the terms of the agreement.

Typical issues that may cause a claim denial or underpayment are:

- o Service codes or modifiers are different (authorization vs. claim).
- o Claim service dates are out of range as compared to the authorization.
- o Units billed do not match the authorized units.

FRAUD, WASTE & ABUSE

It is everyone's responsibility to help in the fight against Fraud, Waste and Abuse. If you suspect a provider, Member or CPHL staff person(s) is engaged in fraud, waste, abuse or any other questionable activity, report it by calling 1-855-699-5046 or by visiting www.centersplan.ethicspoint.com. Both modes support anonymous reporting.

Drug Interaction Profile:

Concomitant Warfarin And NSAID Use

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) are commonly prescribed in many dosage forms for a variety of different indications. NSAIDs have been proven to be effective in treating pain in patients with osteoarthritis, rheumatoid arthritis, chronic back pain, and soft tissue pain, among others. However, it is important to be aware, especially in the elderly population, of the drug interaction between NSAIDs and warfarin.

Warfarin is a drug well-known for its narrow therapeutic index and potential for drug, disease and food interactions. It has been shown that concomitant use of warfarin and NSAIDs increases the risk of bleeding, specifically gastrointestinal bleeding. By impairing thromboxane-dependent platelet aggregation, NSAIDs inherently increase the risk of systemic bleeding. When co-administered with warfarin, this potential bleeding effect is increased. Also, NSAIDs have an erosive effect in the gastrointestinal system, which, coupled with the anticoagulant effect of warfarin, causes an increased risk of gastrointestinal bleeding, independent of INR increase.

It is important to note that these two drugs interact in all dosage forms, including topical, oral, etc. Alternative options include acetaminophen and non-medicinal options such as heat patches, etc. It is important to note that, as part of their patient safety monitering efforts, CMS monitors drug-drug interactions and tracks duration of concurrent usage. Please avoid using NSAID medications in patients who are also receiving warfarin.

Complex Care Management At CPHL

In many Medicare Advantage Plans, the majority of Plan Members are not actively care managed; at Centers Plan for Healthy Living (CPHL), however, we take a different approach to our Members, your patients. We believe that a proactive approach to disease management benefits our Members, their families and all parties concerned. Each CPHL Medicare Advantage Member is assigned a Complex Care Manager who completes an assessment and determines the frequency of needed care management interventions. This provides the Member with a direct link into the Complex Care Management Team as another resource to help the Member navigate the healthcare system. The Complex Care Management Team looks forward to partnering with you to assist in educating our Members about their specific disease processes and facilitating access to covered benefits through CPHL's Medicare Plan(s).

Best wishes for a healthy season for all.

HEDIS UPDATE:
Care of Older Adults

Keeping our Members Healthy

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS results are a direct reflection of a Provider's care and should be used as a framework to improve patient care. Audited HEDIS scores form the basis of public report cards by which Health Plans are compared and evaluated.

The HEDIS Care of Older Adults (COA) measure involves assessing functional status and pain, reviewing medications, and discussing advance care planning for patients over 65 years of age. According to the 2010 US Census there were over 40 million Americans 65 years and older, and this population segment is expected to expand over the next ten to twenty years due to aging baby boomers. This measure helps ensure that older adults receive comprehensive care that prevents further health status decline. The COA measures are important to assess because as Members age, physical function decreases, pain increases, and cognitive ability can decrease. Older adults may have increasingly complex medication regimens. This is an important population group where consideration should also be given to their choices for end-of-life care and an advance care plan should be executed. Please make certain that your medical record documents the following elements of care to address these needs:

1. Advance Care Planning: As people age, consideration should be given to their treatment wishes in the event that they lose the ability to manage their care. Advance directives are recommended as a strategy to improve compliance with patient wishes at the end of life. 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:

- Presence of an advance care plan in the medical record.
- 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 the measurement year.
- Notation that the Member previously executed an advance care plan.

2. Medication Review: Many older adults take medications to address at least three or more chronic conditions. Many have multiple prescribing physicians and use more than one pharmacy, necessitating regular review of medications. A medication list should include prescriptions and over-the-counter (OTC) medications (including herbal supplements), doses, frequencies and reasons for taking the medication. Poor medication management can lead to adverse drug events, overdoses, and underutilization of drugs, all of which may result in a hospitalization.

HEDIS

Evidence of Medication Review must include one of the following:

- Presence of a medication list in the medical record, signed and dated by the practicioner (a review of side effects for a single medication at the time of prescription is not sufficient)
- Notation that the Member is not taking any medication and the date when it was noted.

3. Functional Status: Physical ability is an important indicator for health and well-being in older age groups. Physical functional decline may present as an initial symptom of illness and early detection allows for earlier treatment or intervention. Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.

Evidence of functional status review should include the following:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet, or walking.
- 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, or handling finances.
- Result of assessment using a standardized functional status assessment tool.
- Notation that at least three of the following four components were assessed: (1) Cognitive Status; (2) Ambulation Status; (3) Sensory Ability (consisting of assesments of hearing, vision and speech); and (4) Functional Independence (e.g., exercise, ability to perform job).

4. Pain Assessment: Pain may be frequent symptom of illness and disease in older patients. Older patients are more likely to have arthritis, bone and joint disorders, cancer or other chronic disorders associated with pain. The consequences of under-treating pain can have a negative effect on the health and quality of life in the elderly, contributing to depression, anxiety, reduced socialization, sleep disturbances and impaired mobility. Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

Notations for a pain assessment must include one of the following:

- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
- Result of an assessment using a standardized pain assessment tool.

Document the results of all screenings. Get credit for the work you've done! Annual collection and documentation of this patient information is a valuable tool that meets the needs of your patient, while also satisfying HEDIS® measures.

CENTERS PLAN FOR HEALTHY LIVING

CPHL Quick Reference Guide

SERVICE	HOURS OF OPERATION	CONTACT INFO	
Provider Services	9AM – 5PM • Monday - Friday	providerservices@centersplan.com (T) 1-844-292-4211 (Provider Services electronic Fax) 718-581-5562	
Care Management Department	9AM – 5PM • Monday - Friday	Medicare 1-877-940-9330 MLTC 1-855-270-1600 FIDA 1-800-466-2745	
Member Services • Verify CPHL Member Eligibility	8AM – 8PM • 7 days a week	MemberServices@centersplan.com Medicare 1-877-940-9330 MLTC 1-855-270-1600 FIDA 1-800-466-2745	
Utilization Management Department • Services Requiring Prior Authorization	9AM – 5PM • Monday – Friday	serviceauths@centersplan.com Medicare 1-877-940-9330 MLTC 1-855-270-1600 FIDA 1-800-466-2745	
Enrollment Intake Staff	9AM – 5PM • Monday – Friday	enrollment@centersplan.com Medicare 1-877-940-9330 MLTC 1-855-270-1600 FIDA 1-800-466-2745 (Fax) 347-505-7094	
Claims	All Claims must be received within the time frame specified in your provider agreement. Please be sure to include your NPI and TIN on all claims. Please call Provider Services with any questions.	Mail Paper Claims: Relay Health 1564 North East Expressway Mail Stop HQ2361-CPHL Atlanta, GA 30329-2010	Electronic Submission: Payor ID: CPHL To set up electronic claims submission, contact PCS at PCSsupport@mckesson.com or 1-877-411-7271
Pharmacy Services	Part D Drugs are administered through our Pharmacy Benefit Manager, MedImpact. Access our website at www.centersplan.com for our Formulary Listing.		