Provider Newsletter

January 2021

Monroe Plan for Medical Care Provider Portal Coming Soon!

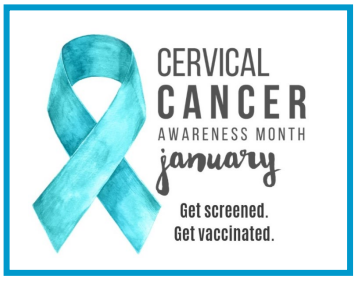
Monroe Plan is excited to announce the upcoming launch of our provider portal. When fully implemented the portal will allow practices to easily update demographic information, access forms and view quality reports. Thank you to the practices that have agreed to test the portal during the month of January. We look forward to incorporating your feedback and making the portal available to our full IPA network.

Quality Matters - Coding Tip of the Month

Accurate coding is critical to maintaining and improving your practice's quality performance and ensuring proper billing. This month's coding tip details proper coding for Hemoglobin (HbA1c) testing for Comprehensive Diabetes Care. Monroe Plan's Clinical Quality team is committed to supporting your practice in achieving the highest quality standards. Please let us know if you need assistance by emailing providerrelations@monroeplan.com.

Quality Measure	Goal	Criteria to Meet the Goal
Hemoglobin A1c (HbA1c) Testing The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) test performed during the measurement year	○ Members will have at least one HbA1c test performed during the measurement year ○ HbA1c Control < 8%: Most recent Hemoglobin A1c (HbA1c) level < 8.0% is considered compliant ○ HbA1c Poor Control > 9%: Most recent Hemoglobin A1c (HbA1c) level > 9.0% or result is missing is considered compliant ○ Medical record documentation must include the date and value of the most recent HbA1c result during the measurement year	**Claims/ Coding:** 83036; 83037 **3044F** – Most recent HbA1c less than 7.0% **3046F** – Most recent HbA1c greater than 9.0% **3051F** – Most recent HbA1c greater than or equal to 7.0% and less than 8.0% **3052F** - Most recent HbA1c greater than or equal to 8.0% and less than 9.0% ** *The date of service reported for CPT II codes 3044F-3046F; 3051F-3052F and the date of service of the test result must be no more than seven days apart*

January is Cervical Cancer Awareness Month



An estimated 13,800 new cases of invasive cervical cancer were diagnosed in the United States in 2020, and approximately 4,290 women will die of the disease this year, according to the American Cancer Society. Please remind your patients of the importance of getting screened every year from age 25 to age 65. More details regarding screening guidelines are provided in the chart below.

TABLE 1. American Cancer Society Recommendations for Cervical Cancer Screening, 2020

The recommendations apply to all asymptomatic individuals with a cervix, regardless of their sexual history or human papillomavirus (HPV) vaccination status, including those who have undergone supracervical hysterectomy and transgender men who retain their cervix.

These recommendations represent guidance from the American Cancer Society (ACS) for persons who are initiating cervical cancer screening or have had all normal cervical cancer screening results in the past, or have been returned to routine cervical cancer screening based on follow-up recommendations from the Risk-Based Management Consensus Guidelines. The recommendations do not apply to individuals at increased risk for cervical cancer due to solid organ or stem cell transplantation, human immunodeficiency virus infection or immunosuppression from other causes, or in utero exposure to diethylstilbestrol.

Recommendations

The ACS recommends that individuals with a cervix initiate cervical cancer screening at age 25 y and undergo primary HPV testing every 5 y through age 65 y (preferred). If primary HPV testing is not available, individuals aged 25-65 y should be screened with cotesting (HPV testing in combination with cytology) every 5 y or cytology alone every 3 y (acceptable) (*strong recommendation*).[a]

Cotesting or cytology testing alone are included as acceptable options for cervical cancer screening because access to primary HPV testing with a test approved by the FDA for primary screening may be limited in some settings. As the United States makes the transition to primary HPV testing, the use of cotesting or cytology alone for cervical cancer screening will be eliminated from future guidelines.

The ACS recommends that individuals with a cervix who are older than age 65 y, who have no history of cervical intraepithelial neoplasia grade 2 or a more severe diagnosis within the past 25 y, and who have documented adequate negative prior screening in the 10-y period before age 65 y discontinue cervical cancer screening with any modality (*qualified recommendation*).[a,b]

- Adequate negative prior screening is currently defined as 2 consecutive negative HPV tests, or 2 consecutive negative cotests, or 3 consecutive negative cytology tests within the past 10 y, with the most recent test occurring within the recommended interval for the test used. These criteria do not apply to individuals who are currently under surveillance for abnormal screening results.
- Individuals older than age 65 y without conditions limiting life expectancy for whom sufficient documentation of prior screening is not available should be screened until criteria for screening cessation are met.
- Cervical cancer screening may be discontinued in individuals of any age with limited life expectancy.

Abbreviation: FDA, US Food and Drug Administration.
[a]A strong recommendation conveys the consensus that the benefits of adherence to that intervention outweigh the undesirable effects that may result from screening. Qualified recommendations indicate there is clear evidence of benefit of screening but less certainty about the balance of benefits and harms or about patients' values and preferences, which could lead to different decisions about screening.
[b]Older than age 65 years means that cervical cancer screening is not recommended for individuals aged 66 years and older.

Batch Eligibility and Claims Status coming to NY

Molina Healthcare of New York, Inc. is currently working with their clearinghouse, SSI/Claimsnet, to implement both 276/277 claims status inquiries as well as 270/271 eligibility inquiries. This allows our provider partners increased productivity and efficiency, decreased duplicate claim submissions, and improved cash flow. We are expecting a launch of the 276/277 process in late December, and if you are already signed up through SSI/Claimsnet, you will receive a notification letting you know the process is live. The launch of the 270/271 batch eligibility process is slated for go live of late January 2021.

Member Benefit Update - Physical, Occupational, and Speech Therapy (PT/OT/ST)

As of January 1, 2021, New York State has removed the service limits on all Physical, Occupational and Speech Therapy services for Medicaid recipients. Instead, medically necessary PT/OT/ST visits that are ordered by a doctor or other licensed professional will be covered. You can find out more information by going to the New York State Website.

COVID Updates

Updates will be made to the Molina Provider COVID resource page as New York State guidance is received. Please be sure to check it regularly for the latest information.

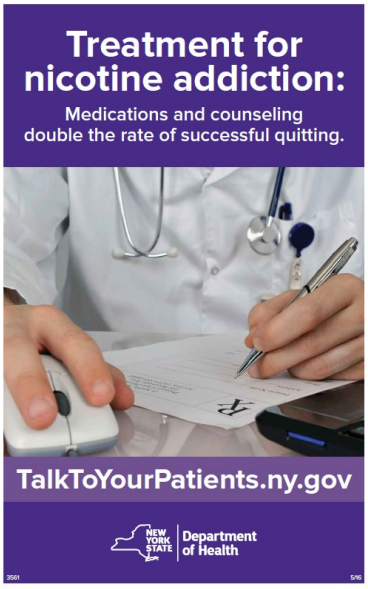
Reminder: Cultural Sensitivity Training

As a follow up to the Monroe Plan/Molina Bulletin distributed on December 17, 2020, this is a reminder that New York State Department of Health requires Health Plans and IPA's that contract with Health Care Providers to ensure providers have access to and complete Cultural Competency training.

A series of short Cultural Competency Training videos are available on Molina's website on the Culturally and Linguistically Appropriate Resources page listed under the Health Resources tab. Topics covered include: How Culture Impacts Health Care, Health Disparities, Social Determinants of Health, Seniors and Persons with Disabilities, LGBTQ Population, Immigrant and Refugee Populations, Perspective-taking and Molina's Language Access Services.

If you have completed any NYS based cultural competency training on-line, please notify us at **providerrelations@monroeplan.com** and attach a copy of your NYS completion certificate. Thanks for your cooperation!

SMOKING CESSATION



Five Major Steps to Intervention (The "5 A's")

Successful intervention begins with identifying users and appropriate interventions based upon the patient's willingness to quit. The five major steps to intervention are: Ask, Advise, Assess, Assist, and Arrange.

1. **Ask** - Identify and document tobacco use status for every patient at every visit. (You may wish to develop your own vital signs sticker, based on the sample below).
2. **Advise** - In a clear, strong, and personalized manner, urge every tobacco user to quit.
3. **Assess** - Is the tobacco user willing to make a quit attempt at this time?
4. **Assist** - For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit.
5. **Arrange** - Schedule follow up contact, in person or by telephone, preferably within the first week after the quit date.

Monroe Plan for Medical Care and Molina HealthCare of New York Inc. look forward to partnering with you throughout 2021 and beyond!