Provider Outreach Manual:
Medicare Advantage Part C STAR Measures

www.MercyCareAdvantage.com
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Medicare Stars Program

The Centers for Medicare and Medicaid Services (CMS) works with Medicare Advantage Plans like Mercy Care Advantage to improve the quality and cost effectiveness of services provided to beneficiaries.

Star Ratings are a way for consumers to compare the relative quality of Medicare Advantage Plans. The Centers for Medicare & Medicaid Services (CMS) issue the ratings based on administrative results, clinical outcomes and plan member surveys.

**NCQA - HEDIS® Quality Measures**

Healthcare Effectiveness Data and Information Set (HEDIS®) is a performance measurement tool developed and maintained by National Committee for Quality Assurance (NCQA) and used by the Centers for Medicare & Medicaid Services for monitoring the performance of managed care organizations. HEDIS® is designed to allow consumers and plan sponsors to compare health plan performance to other plans.

- It is important to understand that HEDIS® measures require the NCQA technical specifications for calculating.
- All health plans are required to use the same technical specifications and all source code is audited by an external third party, thereby making the results comparable across the industry. The consistent methodology also allows for trending rates year over year.
- HEDIS® measures are obtained by one or more of three data collection methodologies:
  a. Administrative - The administrative method is used to identify the eligible population and numerator using transaction data or other administrative databases (e.g. claims or encounter data).
  b. Hybrid - The hybrid methodology scores numerator compliance from both administrative and medical record data.
  c. Survey - The survey methodology requires that the data be collected through a survey.
     i. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
     ii. The Medicare Health Outcomes Survey (HOS)

The HEDIS® medical record data abstraction process for hybrid measures begins each year in February and continues through mid-May. Mercy Care Plan will be contacting your office by way of a fax. This fax will include a pull list containing members for which we are requesting medical records for one or more of the HEDIS measures as well as an explanation of what documentation is required for each measure. The records you provide to us during this process help us to validate the quality of care provided to our members.

The following measures are reviewed during HEDIS® medical record data abstraction:

- ABA- Adult BMI Assessment
- CBP- Controlling High Blood Pressure
- CDC- Comprehensive Diabetes Care
- COA- Care for Older Adults
- COL- Colorectal Cancer Screening
- MRP- Medication Reconciliation Post-Discharge
- PPC- Prenatal and Postpartum Care
How You Can Help - during the entire measurement year:

- Making sure patients receive routine check-ups, screening tests, vaccines and preventive services.
- Managing patient care for chronic conditions by prescribing certain tests and treatments that help patients manage their conditions.
- Ensuring patients are continually taking their medications: Specifically for diagnoses of Rheumatoid Arthritis, COPD, Hypertension, Osteoporosis, and Diabetes.
- Submitting claims and documenting all services thoroughly and accurately.
- Understanding the impact that you and your office staff have on your patients’ (our members’) satisfaction with their health experience, which is reflected in CAHPS and HOS surveys.
- Signing up for MercyOneSource. Mercy Care Advantage providers have access to a secure online portal that gives you direct access to provider reports.

How You Can Help - during medical record review season:

- Assisting with the HEDIS® Medical Record Review Audit by providing records as requested for the hybrid medical record data collection.
- Responding to our requests for medical records within 14 days.
- Submitting ONLY the requested information noted by the sub measure key on the pull list.
- Paying close attention and providing the appropriate records of care within the designated timeframes.

How to get records to Mercy Care Plan:

Fax: 860-907-3430

Mail: Attention: Laura Broughton RN, BSN / Mercy Care Plan
4350 E Cotton Center Blvd., Bldg. D
Phoenix, AZ 85040

Schedule an onsite visit: (Please keep in mind that if you have under five members on your pull list, we respectfully request that you submit the records to the plan.)

Paper records: Mercy Care Plan uses scanning, by scanner or iPad for paper records. The downloads are fully encrypted and password protected.

EMRs: Mercy Care Plan will download the records onto an encrypted and password protected flash drive. From there the records are uploaded to a fully encrypted and password protected secure portal.

Things to remember: Protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules and does not require consent or authorization from the member/patient.

According to the Mercy Care Advantage provider manual:

4.25 - Medical Record Audits
MCA will conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when MCA is responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. Providers must respond to these requests within fourteen (14) days or in no event will the date exceed that of any government issues request date. Medical records must be made available to AHCCCS for quality review upon request. MCA shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Annual Flu Vaccine</td>
<td>CAHPS</td>
</tr>
<tr>
<td>Improving or Maintaining Physical Health</td>
<td>HOS</td>
</tr>
<tr>
<td>Improving or Maintaining Mental Health</td>
<td>HOS</td>
</tr>
<tr>
<td>Monitoring Physical Activity</td>
<td>HEDIS® /HOS</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Care for Older Adults – Medication Review</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Care for Older Adults – Functional Status Assessment</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Care for Older Adults – Pain Assessment</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Osteoporosis Management in Women who had a Fracture</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Diabetes Care – Eye Exam</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Diabetes Care – Kidney Disease Monitoring</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Diabetes Care – Blood Sugar Controlled</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Rheumatoid Arthritis Management</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Reducing the Risk of Falling</td>
<td>HEDIS® /HOS</td>
</tr>
<tr>
<td>Plan All-Cause Readmissions</td>
<td>HEDIS®</td>
</tr>
<tr>
<td>Getting Needed Care</td>
<td>CAHPS</td>
</tr>
<tr>
<td>Getting Appointments and Care Quickly</td>
<td>CAHPS</td>
</tr>
<tr>
<td>Customer Service</td>
<td>CAHPS</td>
</tr>
<tr>
<td>Rating of Health Care Quality</td>
<td>CAHPS</td>
</tr>
<tr>
<td>Rating of Health Plan</td>
<td>CAHPS</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>CAHPS</td>
</tr>
</tbody>
</table>
What is the HEDIS Gaps in Care Report?

• A new monthly report that providers can access via Pro Report, the secure provider web portal.
• Based on a select set of HEDIS measures
• Compares provider group performance to the health plan overall performance as well as NCQA benchmarks on this set of HEDIS measures
• Most importantly, it has a member list of needed care or services that providers can use to address ALL gaps in care when patients are in the office or for outreach to patients. This list is provider level specific.
• This report will be available to all Mercy Care Plan primary care physicians.

The best ways for providers to use the HEDIS Gaps in Care Report

TIPS FOR SUCCESS WITH USING THE REPORTS:

• Have an assigned staff person in the office access the report each time a new one is available and save it to the office computer for ease of access and manipulation.
• The provider can access the report while with the patient or have a staff member add alerts to the EMR indicating services are due or print and place on paper charts if needed
• Have staff call to schedule an appointment for members with gaps in care that have not been seen recently or have missed follow up care/services recommended
• Outreach to members on the report that are not established in your practice and schedule them for a routine physical

The HEDIS Gaps in Care Report has five tabs

1. A cover letter with plan quality contact information.
2. Medicaid Performance Summary
3. Medicare Performance Summary
4. Members Needing Care-Services
5. List of HEDIS Measures
Dear Valued Provider:

It is with great pleasure that we are introducing our new Member Gaps in Care Report. Mercy Care Plan and Mercy Care Advantage (HMO SNP) are committed to working with our providers in achieving the triple aim as defined by the Institute of Healthcare Improvement:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations; and
- Reducing the per capita cost of healthcare

Our goal is to assist our providers by identifying members needing care while recognizing opportunities for improvement in the delivery of primary care services. Mercy Care Plan and Mercy Care Advantage (HMO SNP) embrace the standard of care in the Patient Centered Medical Home Model and utilize the Healthcare Data and Information Set (HEDIS®) from the National Committee for Quality Assurance (NCQA) to capture the overall health and wellness of our membership and identify members in need of care, follow-up, and patient education.

HEDIS® includes 83 measures across 5 domains of care: Effectiveness of Care, Access/ Availability of Care, Experience of Care, Utilization and Relative Resource Use, and Health Plan Descriptive Information.

Your Provider Group’s Gaps in Care Report was created using the HEDIS® metrics identified as “Measures of Focus.” It is important to note that not all of the HEDIS® measures may apply to your member panel. The report includes a summary of your group performance by product line in each measure applicable to your practice, a detailed list of the members assigned to your panel that are still in need of care and services by a primary care provider or by specialist where indicated*. A Gaps in Care Technical Specifications and CPT Billing Guide from HEDIS® have been included for your reference.

The Gaps in Care Technical Specifications and CPT Billing Guide from HEDIS® is a comprehensive guide that contains important information about each of the HEDIS® measures, the care and services needed, and corresponding CPT/ICD-9-CM or ICD-10 codes specific to each measure.

Mercy Care Plan and Mercy Care Advantage (HMO SNP) have many different outreach initiatives and programs in place to service our membership. Our goal is to work hand-in-hand with our primary care physicians, to identify and eliminate gaps and barriers to care. Also, we recognize and share best practices to improve the overall health of our membership.

If you have any questions about your Member Gaps in Care Report or would like to schedule a meeting to discuss your reports or coordinate a member outreach initiative, please contact Cynthia vanRossum, RN, BSN at 520-262-5874, Tucson or Laura Broughton, RN, BSN at 602-619-1724, Phoenix.

We look forward to working collaboratively in continuing to provide superior care and excellent service to our membership.

Sincerely,

Charlton Wilson, MD, FACP, FACHE
Chief Medical Officer
Mercy Care Plan, Mercy Care Advantage
# Medicaid Gaps in Care Summary

This tab will show the providers groups level for:

- Measures for Medicaid population
- Group Performance: eligible members, compliant members, those members needing care
- Comparison rates: Your rates and Health Plan rates
- NCQA National HMO Medicaid benchmarks for 50, 75 and 90 percentiles

## Medicaid Gaps in Care Summary

**HEDIS Rates Based on claims received 01/01/2015 to 08/31/2015**

**Report Prepared for:**  
0

*Inverse* Measure - Lower rate = Better performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Your Group Performance</th>
<th>Comparison Rates</th>
<th>2014 NCQA National HMO Medicaid Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible Members</td>
<td>Compliant Members</td>
<td># Members Needing Care</td>
</tr>
<tr>
<td>Adult BMI Assmt (ABA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMARD Rheum Arthr (ART)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolesc Well Care (AWC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer (BCS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure (CBP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer (CCS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp Diabetes (CDC) BP Control &lt;140/90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp Diabetes (CDC) HbA1c Poor Control &gt;9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp Diabetes (CDC) Monitoring for Nephropathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screen (CHL) Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Imin (CIS) Combination 1 Immunizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV for Female Adolescents (HPV)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imins Adolescents (IMA) Combination 1 Immunizations</td>
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</tr>
</tbody>
</table>
Tab No. 3  
**Medicare Gaps in Care Summary**

This tab will show the providers group level for:

- Measures for Medicare population
- Group Performance: eligible members, compliant members, those members needing care
- Comparison rates: Your rates and Health Plan rates
- NCQA National HMO Medicaid rates for 50, 75 and 90 percentiles

### Medicare Gaps in Care Summary

**HEDIS Rates Based on claims received 01/01/2015 to 08/31/2015**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Your Group Performance</th>
<th>Comparison Rates</th>
<th>2014 NCQA National HMO Medicare Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible Members</td>
<td>Compliant Members</td>
<td># Members Needing Care</td>
</tr>
<tr>
<td>Adult BMI Assmt (ABA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMARD Rheum Arthr (ART)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer (BCS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure (CBP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp Diabetes (CDC) BP Control &lt;140/90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp Diabetes (CDC) HbA1c Poor Control (&gt;9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp Diabetes (CDC) HbA1c Control &lt;8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comp Diabetes (CDC) Monitoring for Nephropathy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Inverse* Measure - Lower rate = Better performance.
Tab No. 4  **Medicaid and Medicare Members who have Gaps in Care Summary**

As you scroll through the list of measures on the Members Needing Care-Services tab, you will see:

- **NC** in the member column for those that are in need of care or services
- **PE** in the member column for those that need education or follow-up
- In the column means not applicable OR the member has already received the needed care to satisfy the measure
- The member listing can be filtered by individual providers in your provider group in column G.
- This member listing also includes the member demographics for provider ease of contacting members.
- If you have both a Medicaid plan as well as a Dual Medicaid/Medicare Plan, your member list will be combined from both plans.

This example would indicate that the member needs care for hypertension. This list can be used to assist the providers’ office with member outreach.

---

**Table:**

<table>
<thead>
<tr>
<th>Member ID (Medicaid ID)</th>
<th>Member Name</th>
<th>Date of Birth</th>
<th>Member Address</th>
<th>Member ZIP Code</th>
<th>Phone Number</th>
<th>PCP</th>
<th>CBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>0541000000</td>
<td>RAY, WHO</td>
<td>02/06/1967</td>
<td>310 NORTH ST CENTER NE</td>
<td>68724</td>
<td>555-1212</td>
<td>ProA</td>
<td>--</td>
</tr>
<tr>
<td>054100001</td>
<td>DUNNIT, WHO</td>
<td>01/27/1988</td>
<td>310 NORTH ST CENTER NE</td>
<td>68724</td>
<td>--</td>
<td>ProA</td>
<td>NC</td>
</tr>
<tr>
<td>054100002</td>
<td>WANTSMORE, WHO</td>
<td>05/06/1974</td>
<td>68927 541 AVE BLOOMFIELD</td>
<td>68710</td>
<td>411</td>
<td>ProA</td>
<td>--</td>
</tr>
<tr>
<td>054100003</td>
<td>SCONNACLEANT UP WHO</td>
<td>03/03/1966</td>
<td>807 YOUNGST CREIGHTON NE</td>
<td>68729</td>
<td>555-1212</td>
<td>ProA</td>
<td>--</td>
</tr>
</tbody>
</table>
Tab No. 5  

HEDIS Measures

List of HEDIS Measures with:

- Measure Mnemoni- i.e.: ABA
- HEDIS Measure: i.e.: Adult BMI Assessment
- Long Measure Description: i.e.: The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year.

<table>
<thead>
<tr>
<th>Measure Mnemoni</th>
<th>HEDIS Measure</th>
<th>Long Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABA</td>
<td>Adult BMI Assessment</td>
<td>The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.</td>
</tr>
<tr>
<td>ART</td>
<td>Disease-Modifying Anti-Rheumatic Drug Therapy/or Rheumatoid Arthritis</td>
<td>The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying antirheumatic drug (DMARD).</td>
</tr>
<tr>
<td>AVC</td>
<td>Adolescent Well-Care Visits</td>
<td>The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</td>
</tr>
<tr>
<td>BCS</td>
<td>Breast Cancer Screening</td>
<td>The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.</td>
</tr>
</tbody>
</table>

There is a separate HEDIS Coding and Tips Sheet that can be found within ProReport portal. This document describes every measure with documentation and coding tips. Many of the measures become satisfied administratively when proper coding is utilized on claims.
MERCYONESOURCE PROVIDER WEB PORTAL 
REGISTRATION FORM

Thank you for your interest in registering for the Provider Web Portal owned or operated by Aetna. We are committed to protecting the privacy of our Providers. We will use our best efforts to ensure that the information you submit to us is used only for the purpose of obtaining access to the Provider Web Portal and remains confidential. We do not disclose any of the information you provide to us to any outside parties, except to manage the health plan or when we think the law may require it.

Registration Instructions: The information below and acceptance of the attached Provider Web Portal Agreement is required to complete registration.

<table>
<thead>
<tr>
<th>Contracted Provider Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Office Name:</td>
<td></td>
</tr>
<tr>
<td>Provider Office Contact Name/Office Manager Name:</td>
<td></td>
</tr>
<tr>
<td>Provider Office Contact Name/Office Manager E-Mail:</td>
<td></td>
</tr>
<tr>
<td>Provider Tax ID # (TIN):</td>
<td></td>
</tr>
<tr>
<td>National Provider ID # (NPI):</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
<tr>
<td>Phone #:</td>
<td>Fax #:</td>
</tr>
</tbody>
</table>

We caution against using your SSN in lieu of a TIN, as it presents unnecessary risks to your identity.

Provider must designate a Primary Representative from their office (see attached Provider Web Portal Agreement for full definition). The Primary Representative may have the ability to add authorized representatives within Provider’s office to Provider’s account. Please provide the following information for the Primary Representative:

<table>
<thead>
<tr>
<th>Primary Representative Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone #:</td>
<td>Fax #:</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Provider Office: Yes</td>
<td>No</td>
</tr>
<tr>
<td>E-Mail address at Provider’s Office:</td>
<td></td>
</tr>
</tbody>
</table>

To submit a request for registration, please fax or e-mail your completed form and the attached signed Provider Web Portal Agreement to: Mercy Care Plan at 860-975-3201.

Please contact your Provider relations representative with any questions at: 602-263-3000 or 800-624-3879.

Signature: ____________________________ Print Name: ____________________________
Provider Group Administrator or Contracted Physician Date: ____________________________

IMPORTANT: A signed provider’s Web Portal Agreement (attached) must accompany this form before registration can be completed. Thank you.
MERCYONESOURCE PROVIDER WEB PORTAL AGREEMENT

This Provider Web Portal Agreement ("Agreement") contains the terms and conditions that govern Provider’s use of the web portal service to access certain Plan member information. By signing the Provider Web Portal Agreement, you acknowledge that you understand and agree to follow the terms and conditions outlined herein.

Definitions

When used in this Agreement, all capitalized terms shall have the following meanings:

“Administrator” means any Aetna administrator, such as Aetna Medicaid Administrators, LLC, and any owners, affiliates or direct or indirect subsidiaries that administer or maintain the Service for a Plan.

“Authorized Representative” means a person that Provider has authorized to use the Service under this Agreement on Provider’s behalf.

“Plan” means a member’s health care benefits as set forth in the state contract with the government sponsor, which is administered by Plan or an Administrator.

“Primary Representative” means the Authorized Representative in Provider’s office with responsibility for adding, deleting, and maintaining the names of Provider’s Authorized Representatives on Provider’s behalf.

“Provider” means the person or entity contracted with Plan or Administrator to provide medical services or supplies to Plan enrollees.

“Service” means the web portal service under this Agreement and the website that supports it.

Provider’s Use of the Web Portal Service

The Service provides internet access to information on Plan member eligibility, claims payments, Plan or Administrator policies and prior authorizations. Provider shall use the Service solely in connection with the provision of health care services to Plan members under the provider’s care. The Primary representative and each Authorized Representative shall use the Service solely in the course and scope of employment or agency with Provider. Provider, the Primary Representative, and each Authorized Representative shall use the Service subject to the following conditions:

1. The terms and conditions of this Agreement; and

2. If applicable, the provisions of Provider’s contract with Plan or Administrator to provide health care services to Plan members (the “Provider Contract”). The applicable provisions of the provider Contract include, but are not limited to, use and disclosure of protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards, member eligibility verification, utilization management standards within Plan policies and the provider manual, and timelines for submission and resubmission of claims.

3. In the event of a conflict between the terms and conditions of this Agreement and those contained in the Provider Contract, this Agreement shall govern.

Provider shall, and shall require the Primary Representative and each Authorized Representative to:

1. Keep confidential and not disclose the Provider’s Service password to any person except Provider or the Primary Representative;

2. Use the Service solely in connection with provider’s health care services to members of Plan, and within the course and scope of employment or agency with Provider; and

3. Use the Service pursuant to the terms and conditions of this Agreement.
Upon learning that the Primary Representative or an Authorized Representative has violated (1), (2) or (3), or no longer works for, or represents Provider, Provider shall immediately revoke such Primary Representative’s or Authorized Representative’s access to the Service. Provider shall also promptly notify Administrator or Plan when it has revoked a Primary Representative’s or an Authorized Representative’s authority to use the Service for any reason. Further, Provider agrees to revoke the Primary Representative’s authority to use the Service if directed to do so by Administrator or Plan.

If an Authorized Representative’s authority is revoked, the Primary Representative shall immediately delete such person’s access to the Service following Plan or Administrator procedures. If the Primary Representative’s authority is revoked, Provider shall immediately delete such person’s access to the Service and designate a new Primary Representative following Plan or Administrator procedures.

Site System Integrity

Provider may not use any device, software routine or agent to interfere, or attempt to interfere, with the proper working of the Service. Provider may not take any action that imposes an unreasonable or disproportionately large load on Administrator’s or Plan’s infrastructure. Provider may not disclose its password to third parties, except an Authorized Representative. Provider shall take reasonable precautions to secure its password from any unauthorized use. Provider may not attempt to log in with a user name or password other than its own.

Confidential Information

“Confidential Information” means any information that identifies a member and relates to the member’s participation in a Plan, the member’s physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care to the member. Confidential Information includes, without limitation, “individually identifiable health information,” as defined in 45 C.F.R. § 160.103 of HIPAA and “non-public personal information,” as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999

Provider acknowledges that Administrator or Plan will provide Confidential Information to Provider solely for Provider’s use in performing agreed upon health care services. Accordingly, Provider agrees to:

1. Comply with all applicable state and federal laws, rules, regulations, licensing or regulatory requirements for each state in which services are provided;
2. Maintain a data privacy and security program and process that complies with all applicable laws and regulations;
3. Implement administrative, physical, and technical safeguards to protect any and all Confidential Information from unauthorized access, use and disclosure; and
4. Not to use or disclose Confidential Information for any purpose other than as specifically permitted herein.

Provider acknowledges that certain laws, including 45 C.F.R. 164.504(f), may prohibit certain uses or redisclosures of Confidential Information. Accordingly, Provider agrees that in no event shall Provider use or redisclose Confidential Information in any manner or for any purpose prohibited by applicable law, regulation, or other legal mandate. Provider may not disclose Confidential Information to any third party whatsoever, including, but not limited to, any broker, consultant, auditor, reviewer, administrator or agent unless Administrator or Plan provides advance written consent of such disclosure.

Provider agrees to accept and comply with policies of which Provider knows or reasonably should have known (e.g., clinical policy bulletins or other policies made available to Provider). Provider will utilize electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions, if available and applicable and to the extent such electronic real time features are utilized by Plan or Administrator.
Provider shall promptly notify Administrator or Plan in the event of: 1) any loss, accidental, or unauthorized disclosure of Confidential Information; 2) any unauthorized access to the Service; 3) any breach of Provider’s data privacy, security program and policies, or safeguards affecting access to the Service and information therein.

Changes to the Web Portal Service or This Agreement
Administrator or Plan may, at any time, make changes to the Service, the terms and conditions of this Agreement, or any other policies or conditions that govern the use of the Service at any time. Provider should review the Service and these terms and conditions periodically for any updates or changes. Provider’s continued access or use of the Service shall be deemed Provider’s notification and acceptance of such changes.

No Warranties or Liabilities
There is no implied warranty of any kind under this Agreement, including of representation about the accuracy, completeness, or appropriateness or fitness for a particular part of the Service, and non-infringement. Provider assumes full responsibility for using the Service, and understands and agrees that neither the Plan nor Administrator are responsible or liable for any claim, loss, or damage resulting from, or related to, Provider’s use. Provider uses the Service at its own risk, and agrees to use the Service on an “AS IS” and an “AS AVAILABLE” basis. Neither Plan nor Administrator will be liable for any delay, difficulty in use, inaccuracy or incompleteness of information, computer virus, malicious code, loss of data, compatibility issues, or otherwise. Plan and Administrator will not be liable for any direct, indirect, incidental, consequential, or punitive damages arising out of the Provider’s use of, or access to, the Service, or any link provided to another site, even if Plan or Administrator was advised of the possibility of such damages, or even if such damages were foreseeable.

Ownership, License and Restrictions on Use of Materials
All right, title and interest (including all copyrights, trademarks and other intellectual property rights) in the Service belong to Plan or Administrator. In addition, the names, images, pictures, logos, and icons are proprietary marks that belong to Plan or Administrator. Except as expressly provided below, nothing contained herein shall be construed as conferring any license or right under copyright or other intellectual property rights.

Provider is hereby granted a nonexclusive, nontransferable, limited license to view and use information retrieved from the Service solely in connection with the provision of health care services to Plan members.

Except as expressly provided above, no part of the information in or about the Service, including but not limited to materials retrieved from it and the underlying code, may be reproduced, republished, copied, transmitted, distributed, or modified in any form or by any means. In no event shall information or materials from the Service be stored in any storage or retrieval system without prior written permission from Administrator or Plan.

Provider’s use of the Service allows Plan and Administrator to gather certain limited information about Provider and its use of the Service. Provider agrees and consents to the use of such information in aggregated form.

Termination
Provider, Plan or Administrator may terminate this Agreement for any reason at any time.

Plan or Administrator may issue Provider a warning, temporarily suspend, indefinitely suspend, or cancel this Agreement with Provider and Provider’s access to the Service if, in the sole discretion of Plan or Administrator, Provider breaches this Agreement. Plan and Administrator reserve the right to immediately suspend or deny, in their singular or joint discretion, Provider’s access to all, or any portion of, the Service with or without prior notice. Provider acknowledges and agrees that Plan or Administrator may immediately bar any further access to the Service. Provider agrees that neither Plan nor Administrator shall be liable to Provider or any third-party for any termination of Provider’s access to the Service.
Upon termination of this Agreement, Provider agrees to destroy all information and materials, in any format or capacity, obtained or retained from the Service.

**Governing Law**

This Agreement and the rights and obligations of the Provider and Plan or Administrator shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the state where Plan is located. Before Provider may seek legal recourse for any harm Provider believes it has suffered from use of the Service, Provider will give Plan or Administrator written notice specifying the harm and allow Plan or Administrator thirty (30) days from the date of notice to cure the harm. Provider must initiate any cause of action under this Agreement or related to the Service within one (1) year after the claim has arisen or Provider is barred from pursuing any cause of action.

**Entire Agreement**

This Agreement (including any attached schedules, appendices and/or addenda) constitutes the complete and sole agreement between Provider and Plan or Administrator regarding the subject matter described herein and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. The parties acknowledge that each Plan or Administrator is a third-party beneficiary of this Agreement.

The signatory below represents and warrants that he or she has full authority to bind the Provider, including the Provider’s owners, employees, agents and representatives, on whose behalf the person below signs.

**Agreed and Accepted:**

<table>
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<tr>
<th>Signature:</th>
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<tr>
<td>Printed Name:</td>
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<tr>
<td>Title:</td>
</tr>
<tr>
<td>Contracted Provider Name:</td>
</tr>
<tr>
<td>Provider Office Name:</td>
</tr>
<tr>
<td>Provider Tax ID # (TIN):</td>
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</tbody>
</table>
  We caution against using your SSN in lieu of a TIN, as it presents unnecessary risks to your identity. |
| National Provider ID # (NPI): |
| Date: |
Welcome to the Provider Report Management Tool

This secure online tool gives you direct access to provider reports. To determine if you or providers in your group have reports available, please log on to the secure provider web portal at www.MercyCarePlan.com. The MercyOneSource link is located at the top right of the home page.

See the enclosed quick reference guide to help you use the Provider Report Management Tool. Once in the tool, select options in the drop-down menus as follows:

- **Report Selection OPTIONS:**
  - Provider – name of the provider
  - Report Type – type of report you would like to view or download
  - Report Period – reporting period you would like to view or download

The search results will populate and filter automatically depending on the options selected.

**Note:** In some cases, individual provider reports roll up to the practice level. You can select the practice from the provider drop-down to see if respective reports are available.

- **Report Selection RESULTS**
  - Available reports are displayed as hyperlinks directly beneath the results section
  - Clicking on a report name hyperlink will give you the option to open or save the report

**Note:** In some cases, report search results may include additional documentation such as report instructions or guides. When reviewing results, please be sure to review any supplemental materials.

For additional information such as preventive health resources and health plan contacts, see the links on the left of the Provider Reports Tool webpage.

**Questions**
If you have questions about the Provider Report Management Tool or your reports, please contact your Provider Relations representative. If you do not know who your provider relations representative is, please go to www.MercyCarePlan.com and utilize the Find your Provider Representative link under the Provider Tab.
Accessing Gaps in Care Reports within ProReport

NOTE: You must have access to the MercyOneSource Provider Secure Web Portal on Mercy Care’s website (http://www.mercycareplan.com/) in order to access ProReport. Please see page 4 for instruction on registering for MercyOneSource.

Mercy Care Website

To access the Mercy Care Plan website, follow the links shown above or click the link listed here: http://www.mercycareplan.com

Once you are on the page, you can access MercyOneSource by selecting the MercyOneSource link.

Sign In Page

Enter your User Name and Password in the appropriate fields.

Click on the "Sign In" button to open the Portal Welcome Page.
At the bottom of the screen, locate "Provider Report Management."

Click on this to open your ProReport home page

Provider Report Management Tool—

Make sure the correct provider ID is displayed to ensure that you have access to the HEDIS Gaps in Care reports and select the hyperlink to the report you wish to view.
Registering for Mercy One Source secure web portal

If you are not currently registered with MercyOneSource – you can find the registration form under the Provider Link on our website www.MercyCarePlan.com

After filling out the form, fax back pages 1 & 5 to:

860-975-3201
Importance of Documentation

Principles of the medical record and proper documentation:

1. Enable physician and other healthcare professionals to evaluate a patient’s healthcare needs and assess the efficacy of the treatment plan
2. Serves as the legal document to verify the care rendered and date of service
3. Ensure date of care rendered is present and all documents are legible
4. Serves as communication tool among providers and other healthcare professionals involved in the patient’s care for improved continuity of care
5. Facilitates timely claim adjudication and payment
6. Missing or lack of all required documentation components
7. Service provided without claim/encounter data submitted
8. Lack of referral to obtain the recommended service (i.e. diabetic member eye exam to check for retinopathy)
9. Service provided but outside of the required time frame or anchor date (i.e. Lead screening performed after age 2)
10. Incomplete services (i.e. Tdap given but no Meningococcal vaccine for adolescent immunization measure)
11. Failure to document or code exclusion criteria for a measure

Common reasons members with PCP visits continue to need recommended services/procedures:

1. Missing or lack of all required documentation components
2. Service provided without claim/encounter data submitted
3. Lack of referral to obtain the recommended service (i.e. diabetic member eye exam to check for retinopathy)
4. Service provided but outside of the required time frame or anchor date (i.e. Lead screening performed after age 2)
5. Incomplete services (i.e. Tdap given but no Meningococcal vaccine for adolescent immunization measure)
6. Failure to document or code exclusion criteria for a measure

Look for the 'Common Chart Deficiencies and Tips' sections for guidance with some of the more challenging HEDIS measures.
Mercy Care Plan and Mercy Care Advantage HMO SNP

Gaps in Care Report Frequently Asked Questions

1. **Q. Where do I find my Gaps in Care Report?**
   A. The Gaps in Care Report is located in the Provider Report Management Tool (ProReport) which is accessed via the Provider Portal.

2. **Q. What do I do if the report "locks up"?**
   A. If the report “locks up”, log out of the program and log in again. If you continue to have problems, contact your health plan designated contact person for assistance.
   Cindy vanRossum, RN, BSN at 520-262-5874 Tucson Area
   Laura Broughton, RN, BSN at 602-619-1724 Phoenix Area

3. **Q. I do not recognize some of the names in my reports. Why are there patients listed that do not belong to me?**
   A. Patients on the list are part of your provider panel. They may have been auto assigned to you and as such, will show on your report with their listed gaps in care.

4. **Q. How often are these reports updated?**
   A. The Gaps in Care Reports are updated monthly.

5. **Q. Why are there gaps in care listed for members that I know have received the services?**
   A. The reports are updated monthly but there is still a claims lag. Some services may be complete and still show as a gap. Once the claim is received and the reports update, the gap should be removed. This could also be a coding issue. Refer to the *Gaps in Care Technical Specifications and Billing Guide* document available on the ProReport page to ensure you are coding things properly.

6. **Q. Why are there some measures on the list do not pertain to my practice type?**
   A. This report is used across all lines of business so you may see measures listed that are out of your scope of practice. The measure in question may also be a service for which you need to encourage the patient to see a specialist.

7. **Q. Can I save my Gaps in Care Report outside of the application?**
   A. Yes. It will open in excel and you can save it and manipulate it, however you would like.

8. **Q. Can I print my Gaps in Care Report?**
   A. Yes. Just note that it will probably be a large document. You may want to configure some printing parameters before you hit print.

9. **Q. What do I do if I need my password for the Provider Portal Reset?**
   A. Call the Mercy Care Advantage Provider Relations Department at 602-263-3000 or 1-800-624-3879.
Annual Wellness Visit

CMS is now encouraging providers to regularly review their patients’ wellness and develop plans to keep them healthy.

The Affordable Care Act provides for an Annual Wellness Visit (AWV), including Personalized Prevention Plan Services (PPPS) for Medicare beneficiaries.

The Annual Wellness Visit is a covered benefit for Mercy Care Advantage members and is a preventive wellness visit - NOT a “routine physical checkup.”

Initial Preventive Physical Exam (IPPE) *(during first 12 months of Medicare enrollment)*
Initial preventive physical examination; face-to-face visit **G0402**.

OR

Initial Annual Wellness Visit (AWV)
Annual Wellness Visit including a personalized prevention plan of service **G0438**.

OR

Subsequent Visit
Subsequent annual wellness visit including a personalized prevention plan of service **G0439**.

Tips:
- The Annual Wellness visit provides an excellent opportunity to address additional preventive measures such as:
  1. Flu/Pneumococcal and other adult immunizations
  2. Fall risks assessment
  3. Bone mass measurements
  4. Cancer screenings
  5. Cardiovascular screenings
  6. Diabetic screenings
  7. Screening and behavioral counseling interventions
  8. Screening for depression
  9. Tobacco-use cessation counseling services


- Per CMS guidelines for the Annual Wellness Visit (AWV), when you provide a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service in addition to the AWV, Medicare may pay for the additional service. Report the Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary’s illness or injury or to improve the functioning of a malformed body member.
**Initial Preventive Physical Exam (IPPE) (G0402)**
- Medicare covers an IPPE for all patients who have newly enrolled in Medicare Part B.
- The patient must receive this service within the first 12 months after the effective date of their Medicare Part B coverage.
- The IPPE is a one-time benefit.

The IPPE consists of the following:

1. **Acquire beneficiary information**
   - Review the patient’s medical and social history
   - Review potential risk factors for depression and other mood disorders
   - Review functional ability and level of safety

2. **Begin exam and discussion**
   - Exam: Measurement of height, weight, body mass index (BMI), and visual acuity screening and other routine measurements as deemed appropriate, based on the beneficiary’s medical/family history
   - End-of-life planning (upon agreement of the individual)

3. **Counsel beneficiary**
   - Education, counseling and referral based on the review of previous 5 components
   - Education, counseling and referral for other preventive services, including a brief written plan such as a checklist

The CMS provides a guide entitled “The ABCs of the Initial Preventive Physical Examination”. It can be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf

**Initial AWV with PPPS (G0438)**
- Are not within the first 12 months of their first Medicare Part B coverage period; and
- Have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months.

The initial AWV includes the PPPS and provides for the following services to an eligible beneficiary by a health professional:

1. **Acquire beneficiary information**
   - Administer Health Risk Assessment (HRA). For more information about HRAs, including a sample HRA, refer to www.cdc.gov/policy/ohsc/HRA/FrameworkForHRA.pdf on the CDC website.
   - Establishment of a list of current providers and suppliers
   - Establishment of an individual’s medical/family history
   - Review the beneficiary’s potential risk factors for depression, including current or past experiences with depression or other mood disorders
   - Review the beneficiary’s functional ability and level of safety

2. **Begin assessment**
   - Assess: Measurement of an individual’s height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary’s medical/family history.
   - Detection of any cognitive impairment that the individual may have as defined in this section

3. **Counsel beneficiary**
   - Establishment of a written screening and immunization schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual’s health status, screening history, and age-appropriate preventive services covered by Medicare
• Establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an Initial Preventive Physical Examination (IPPE), and a list of treatment options and their associated risks and benefits.
• Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

Subsequent AWV/PPPS (G0439)
• Has not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months

The Subsequent AWV includes the PPPS and provides for the following services to an eligible beneficiary by a health professional:

1. Acquire update of beneficiary information
   • Update Health Risk Assessment (HRA). For more information about HRAs, including a sample HRA, refer to www.cdc.gov/policy/ohsc/HRA/FrameworkForHRA.pdf on the CDC website.
   • Update the list of current providers and suppliers
   • Update beneficiaries’ medical/family history

2. Begin assessment
   • Assess: measurement of an individual’s height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary’s medical/family history.
   • Detection of any cognitive impairment that the individual may have as defined in this section

3. Counsel beneficiary
   • Update the written screening and immunization schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual’s health status, screening history, and age-appropriate preventive services covered by Medicare
   • Update the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an Initial Preventive Physical Examination (IPPE), and a list of treatment options and their associated risks and benefits.
   • Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

The CMS provides a guide entitled “The ABC’s of the Annual Wellness Visit (AWV)” Also includes the Subsequent AWV/PPPS. It can be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf
Dear Physician or Health Care Professional:

Mercy Care Advantage (HMO SNP) would like to partner with you in our continued efforts to improve quality care and health outcomes for our members. Medicare Members who receive Part B coverage are entitled to:

- A one-time Initial Preventive Physical Examination (IPPE) during the first 12 months of coverage; OR
- If a member did not receive an IPPE during that time, they are eligible for the initial Annual Wellness Visit (AWV) AND
- After receiving either the IPPE or the initial AWV, members are eligible for the subsequent AWV each year they are covered.

The Annual Wellness Visit provides an excellent opportunity for members and their providers to collaborate on a Personalized Prevention Plan. The Annual Wellness Visit is a covered benefit for Mercy Care Advantage members and is a preventive wellness visit - NOT a “routine physical checkup.” ALL elements must be provided before submitting a claim for the AWV.

Mercy Care Advantage (HMO SNP) is providing information and resources below to support our providers with meeting the elements of both the initial and subsequent Annual Wellness Visits. Additionally, to assist both providers and members with this very important preventive visit, we are providing members with a guide, “Getting the Most From your Annual Wellness Visit.” This guide contains a Health Risk Assessment (HRA) the member can fill out prior to arriving for their AWV, as well as a reminder to bring their medications with them for review.

The CMS provides a guide entitled “The ABC’s of the Annual Wellness Visit (AWV)” portions of which we have included below. The entire document can be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

Some of the elements in an AWV include (this is not an all-inclusive list - refer to the link above for a complete list of required elements):

- Administering a HRA which takes about 20 minutes and includes:
  - Collecting the self-reported information from the beneficiary; You or the beneficiary can complete the HRA before or during the AWV encounter
  - Accounting for the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs and is appropriately tailored to their needs
  - Addressing at least the following topics:
    - Demographic data
    - Self-assessment of health status
    - Psychosocial risks
    - Behavioral risks
    - Activities of Daily Living (ADLs), including, but not limited to: dressing, bathing, and walking
• **Instrumental ADLs**, including, but not limited to: shopping, housekeeping, managing own medications, and handling finances

• Establishing a list of current providers and suppliers

• Documenting the beneficiary’s medical/family history. At a minimum, collect and document the following:
  - Medical events in the beneficiary’s parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk
  - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments
  - Use of **medications and supplements**, including calcium and vitamins

• Reviewing the beneficiary’s potential risk factors for depression, including current or past experiences with depression or other mood disorders
  - Review the beneficiary’s functional ability and level of safety. Assess, at a minimum, the following topics:
    - Ability to successfully perform ADLs
    - Fall risk
    - Hearing impairment
    - Home safety

• Obtaining and assessing the following measurements:
  - Height, weight, body mass index (or waist circumference, if appropriate), and blood pressure
  - Other routine measurements as deemed appropriate based on medical and family history

• Detecting any cognitive impairment the beneficiary may have

• Establishing a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years, as appropriate. Base a written screening schedule on:
  - Age-appropriate preventive services Medicare covers
  - Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP)
  - The beneficiary’s HRA, health status, and screening history

• Furnishing personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs to address:
  - Fall prevention
  - Nutrition
  - Physical activity
  - Tobacco-use cessation
  - Weight loss

• Referring to community-based lifestyle interventions to reduce health risks and promote self-management and wellness.

Some elements in the Subsequent AWV include **(this is not an all-inclusive list - refer to link above for a complete list of required elements):**

• Updating the HRA

• Updating the list of current providers and suppliers

• Updating the beneficiary’s medical/family history

• Obtaining-measuring and assessing the following measurements:
  - Height, weight, body mass index (or waist circumference, if appropriate), and blood pressure
  - Other routine measurements as deemed appropriate based on medical and family history

• Detecting any cognitive impairment the beneficiary may have

• Updating the written screening schedule for the beneficiary
• Furnishing personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs to address:
  o Fall prevention
  o Nutrition
  o Physical activity
  o Tobacco-use cessation
  o Weight loss
• Referring to community-based lifestyle interventions to reduce health risks and promote self-management and wellness.

**HCPCS Codes**

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<th>Physical</th>
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<th>Subsequent Annual Wellness Visit</th>
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<tr>
<td>G0402</td>
<td>G0438</td>
<td>G0439</td>
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Thank you for your continued assistance in improving the health of our members, your patients. Should you have any questions, please contact Cindy vanRossum RN, BSN, QM Project Manager at **520-262-5874** or Laura Broughton RN, BSN, QM Project Manager at **602-619-1724**.

Charlton Wilson, MD, FACP, FACHE  
Chief Medical Officer  
Mercy Care Plan
Breast Cancer Screening

Goal: Increase the percentage of women age 50–74 years of age who had a mammogram to screen for breast cancer.

To achieve this goal, Mercy Care Advantage:

• Sends a quarterly, noncompliant member specific report to Primary Care Providers.
• Sends a yearly member educational mailing providing information on mammography. Included in this mailing, are Medicare-covered mammography facility locations.
• Sends an annual well women reminder during the member’s birth month to remind her of a well women physical and screenings.
• Partners with SimonMed to contact members in need of a mammogram and assist with scheduling the screening.
• Sends an annual noncompliant, member specific mammography order form to Primary Care Providers, requesting a signature, completion of the order form, and return of the order form.
• Call staff outreaches to members when signed mammography order forms are received and assist in scheduling a mammogram for the member.
• Sends an end of year annual incentive letter to members who still are not compliant for mammogram screening. Members will receive a gift card if mammogram is scheduled, form is completed by the radiology facility, and the form is returned prior to the deadline.

Tips:

• This measure evaluates primary screening. Breast ultrasounds, biopsies, MRIs, are not considered appropriate methods for primary breast cancer screening.

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<td>401, 403</td>
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www.MercyCareAdvantage.com
Mammography Order Form below, is an example of a document that will be sent out on a monthly basis to Primary care Providers for members that are in need of a Breast Cancer Screening.

Screening Mammography Order Form

Member Name:
DOB:
ID Number:
Telephone Number:

Please sign below to complete the mammography order for this member:

Primary Care Provider (PCP) name: ____________________________
PCP Signature: ____________________________
Date: ____________________________
PCP Phone number: ____________________________

If the above order form is not signed, please select or indicate reason why in space provided below. Please return signed and unsigned order forms via fax.

☐ I wish to contact the member myself and order the mammogram.

☐ The member already had a mammogram within the last 12 months. Please indicate date of mammogram: ________________ and fax documentation.

☐ The member has a mammogram appointment scheduled on: ________________

☐ The member had a bilateral mastectomy. Please indicate date of surgery: ________________

☐ This member is not my patient.

☐ I have counselled the patient about the value of mammography but they decline the test.

www.MercyCareAdvantage.com
Colorectal Cancer Screening

Goal: To increase the percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.

To achieve this goal, on a yearly basis Mercy Care Advantage:

- Sends noncompliant, member specific Fecal Immunochemical Test (FIT) order forms to Primary Care Providers, requesting a signature, completion of the order form, and return of the order form.
- Call staff outreaches to members when signed FIT order forms are received and assist in getting a FIT kit mailed to the members.
- Sends a member educational mailing providing colorectal cancer screening education.
- Call staff makes follow up calls to members that agreed to a FIT test and after 6 weeks remain noncompliant.

Common chart deficiencies and tips:
1. When a patient declines one screening method, discuss other colorectal cancer screening options.
2. In-office stool testing and digital rectal exams are not considered appropriate methods of screening for colorectal cancer.
3. Make a follow up call if the member is noncompliant after receiving an order for a colorectal cancer screening.

Appropriate screenings are defined as:

- **Fecal occult blood test** (FOBT) or **Guaiac** (gFOBT) or **Immunochemical** (iFOBT) during the measurement year
- **Flexible sigmoidoscopy** during the measurement year or the four years prior to the measurement year
- **Colonoscopy** during the measurement year or the nine years prior to the measurement year

### Codes to Identify Colorectal Cancer Screenings

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>ICD-9 PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOBT</td>
<td>82270, 82274</td>
<td>G0328</td>
<td></td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>45330-45335, 45337-45342,</td>
<td>G0104</td>
<td>45.24</td>
</tr>
<tr>
<td></td>
<td>45345-45347, 45349-45350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>44388-44394, 44397, 44401-</td>
<td>G0105,</td>
<td>45.22,</td>
</tr>
<tr>
<td></td>
<td>44408, 45355, 45378-45393,</td>
<td>G0121</td>
<td>45.23,45.25,</td>
</tr>
<tr>
<td></td>
<td>45398</td>
<td></td>
<td>45.42, 45.43</td>
</tr>
</tbody>
</table>
Fecal Immunochemical Test Order Form below, is an example of a document that will be sent on an annual basis to providers for members that are in need of a colorectal cancer screening.

Fecal Immunochemical Test Order Form
InSure® FIT™

Member Name: 
DOB: 
ID Number: 
Telephone Number: 
__________________________________________________________________________________

Please sign below to complete FIT order for this member:

<table>
<thead>
<tr>
<th>Primary Care Provider (PCP) Name:</th>
<th>PCP Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date: ___________________________  PCP Phone number: ___________________________
Lab account number: ______________  Diagnosis code (required): ______________

If the above order is not signed, please select or indicate reason why in space provided below. Please return signed and unsigned order forms via fax.

- □ The member had: □ FOBT/FIT date _______ within the last 12 months
  □ Colonoscopy/date _______ within the last 10 years
  □ Flexible sigmoidoscopy/date _______ within the last 5 years
  
  If this item is checked: **PLEASE FAX A COPY OF REPORT IF ANY TEST HAS BEEN COMPLETED**

- □ The member has: history of colon cancer: date of diagnosis ____________
  OR  has total colectomy: date of surgery: ____________

- □ Member: □ never seen in office  OR  □ declines all methods of colorectal cancer screening

- □ This member is not my patient.

- □ I wish to contact the member myself and order the FOBT/FIT.

- □ The member meets the criteria of being high risk and other screening needs to be completed. I will contact the member myself OR refer them to: ____________________________

- □ Other: ___________________________________________________________________
Annual Flu Vaccine

This measure is collected using survey methodology. Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan surveys.

Goal: To increase the percentage of Medicare members 65 years of age and older who receive an annual influenza vaccination.

To achieve this goal, each flu season Mercy Care Advantage reaches out to our provider partners with an offer to call members on their behalf and encourage them to make an appointment to get their flu shot.

Providers are also offered the opportunity to request a list of the members assigned to their panels to assist them with any provider-level outreaches.

Tips to improve compliance:

- Take the opportunity at every office visit to review member’s immunization status
- Talk with members about the importance of getting vaccinated every year

CAHPS Survey Question

Have you had a flu shot since July 1, YYYY*

- Yes
- No
- Don’t know

*YYYY= the measurement year
Annual Flu Vaccine

<<Date>>

<<Provider Name>>
<<Provider Address>>
<<City, State, Zip>>

Dear Dr. <<Provider Name>>,

According to the Centers for Disease Control (CDC) recommendations, everyone 6 months of age and over should get a flu vaccine annually if not contraindicated. It is especially important that certain high risk individuals receive flu shots, including those 50 years of age and older, and those with chronic health conditions such as asthma, diabetes and chronic lung disease. It is recommended that the vaccine be administered as soon as it is available, and administration should continue throughout flu season.

Mercy Care Plan (MCP)/Mercy Care Advantage (HMO SNP) understands the importance of flu vaccine administration, and as such, we have several interventions in place to educate and remind members to receive their annual flu shot. Coordinated efforts between the health plan and the member’s PCP are known to have the best outcome, so Mercy Care Plan (MCP)/Mercy Care Advantage (HMO SNP) would like to partner with you to outreach to our members. The plan can provide a list of members that are assigned to your practice and, according to our administrative data, have not received a flu shot this year. If your office is offering the flu vaccine, you can contact the member and assist them in scheduling an appointment with your office, to receive the flu vaccine. Alternately, we can have our call staff make outreach calls to members reminding them to get their flu vaccine. Please make your selection below and fax this document back to 860-907-3430 by October 14.

☐ I wish to contact the member myself. Please provide a copy of my member listing to this fax number:________________________________________

☐ I wish to contact the member myself and do not need a copy of my member listing.

☐ Please have your call staff contact my members to remind them to obtain their flu vaccine.

Members can also get their flu vaccine at participating retail pharmacies. Most pharmacies participate in the flu vaccine program.

The community preventive services task force lists proven methods of increasing vaccine rates and drop-in visits and standing orders. For this reason, Mercy Care Plan (MCP)/Mercy Care Advantage (HMO SNP) would like to encourage you to consider offering these methods of vaccine administration in your practice.
Annual Flu Vaccine

<<Date>>

<<Provider Name>>
<<Provider Address>>
<<City, State, Zip>>

Dear Dr. <<Provider Name>>,

In a recent communication you indicated that you would like to receive a list of Mercy Care Plan (MCP)/Mercy Care Advantage (HMO SNP) members assigned to your panel, who are in need of a flu vaccine. Attached is a listing of members who, based on our administrative data, have not yet had a flu vaccine this year. Please have your office staff contact the members and schedule an appointment for them to receive a flu vaccine. Alternately, consider offering drop-in visits and standing order methods of vaccine administration in your practice.

If you or your staff have any questions or need additional information please contact Laura Broughton, RN, BSN at 602-619-1724 or BroughtonL@MercyCarePlan.com.

Thank you for your continued support of our outreach efforts.

Sincerely,

Charlton Wilson, MD, FACP, FACHE
Chief Medical Officer

Mercy Care Advantage (HMO SNP) is a Coordinated Care Plan with a Medicare contract and a contract with the Arizona Medicaid Program. Enrollment in Mercy Care Advantage depends on contract renewal.
List of Members from Mercy Care Plan (MCP)/Mercy Care Advantage (HMO SNP)

<table>
<thead>
<tr>
<th>Member Name</th>
<th>DOB</th>
<th>AHCCCS ID</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

www.MercyCareAdvantage.com
Improving or Maintaining Physical Health

This measure is collected using survey methodology. Medicare Health Outcomes Survey (HOS).

Goal: To increase the percentage of all plan members whose physical health was the same or better than expected after two years.


2-year PCS change - Questions: 1, 2a-b, 3a-b & 5

HOS Survey Questions

Q 1. In general, would you say your health is:
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

Q 2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
   2a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf
      - Yes, limited a lot,
      - Yes, limited a little
      - No not limited at all
   2b. Climbing several flights of stairs
      - Yes, limited a lot,
      - Yes, limited a little
      - No not limited at all

Q 3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
   3a. Accomplished less than you would like as a result of your physical health?
      - No, none of the time
      - Yes, a little of the time
      - Yes, most of the time
      - Yes, all of the time
   3b. Were you limited in the kind of work or other activities as a result of your physical health?
      - No, none of the time
      - Yes, a little of the time
      - Yes, most of the time
      - Yes, all of the time
Q 5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
Improving or Maintaining Mental Health

This measure is collected using survey methodology. Medicare Health Outcomes Survey (HOS).

Goal: To increase the percentage of sampled plan members whose mental health was the same or better than expected after two years.


2-year MCS change - Questions: 4a-b, 6a-c & 7

HOS Survey Questions

Q 4. During the past 4 weeks, have you had any of the following problems with your work or regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

4a. Accomplished less than you would like as a result of any emotional problems
   - No, none of the time
   - Yes, a little of the time
   - Yes, some of the time
   - Yes, most of the time
   - Yes, all of the time

4b. Didn’t do work or other activities as carefully as usual as a result of any emotional problems
   - No, none of the time
   - Yes, a little of the time
   - Yes, some of the time
   - Yes, most of the time
   - Yes, all of the time
These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give one answer that comes closest to the way you have been feeling.

**Q 6. How much of the time during the past 4 weeks:**

6a. Have you felt calm and peaceful?
   - All of the time
   - Most of the time
   - A good bit of the time
   - Some of the time
   - A little of the time

6b. Did you have a lot of energy?
   - All of the time
   - Most of the time
   - A good bit of the time
   - Some of the time
   - A little of the time
   - None of the time

6c. Have you felt downhearted and blue?
   - All of the time
   - Most of the time
   - A good bit of the time
   - Some of the time
   - A little of the time
   - None of the time

**Q 7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?**

   - All of the time
   - Most of the time
   - Some of the time
   - A little of the time
   - None of the time
Monitoring Physical Activity in Older Adults

This measure is collected using survey methodology. Medicare Health Outcomes Survey (HOS)

**Goals:**

**Discussing Physical Activity:**
To increase the percentage of Medicare members 65 years of age and older who had a doctor’s visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity.

**Advising Physical Activity:**
To increase the percentage of Medicare members 65 years of age and older who had a doctor’s visit in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity.

Cohort 15 Follow-up Data collection (2014) and Cohort 17 Baseline data collection (2014).

**HOS Survey Questions**

**Q46.** In the past 12 months, did you talk with a doctor or other health care provider about your level of exercise or physical activity? For example, a doctor or other health care provider may ask if you exercise regularly or take part in physical activity.

- [ ] Yes
- [ ] No
- [ ] I had no visits in the past 12 months

**Q47.** In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

- [ ] Yes
- [ ] No
Adult body mass index (BMI) Assessment

Goal: Increase the percentage of members 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.

Measure Requirements:
- Members **20 years and older on date of service** must indicate weight and BMI during measure year or year prior
- Members **younger than 20 on date of service** must indicate height, weight and BMI percentile during the measure year or year prior (BMI Percentile documented as a value e.g. 85th percentile OR BMI percentile plotted on an age-growth chart)

Tips:
- **Common deficiency**: No BMI is documented, only height and weight are documented
- ICD-10 codes can be used to make a member compliant without a chart review

### Codes to Identify Body Mass Index (BMI)

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body mass index (BMI) 19 or less, adult</td>
<td>Z68.1</td>
</tr>
<tr>
<td>Body mass index (BMI) 20.0–20.9, adult</td>
<td>Z68.20</td>
</tr>
<tr>
<td>Body mass index (BMI) 21.0–21.9, adult</td>
<td>Z68.21</td>
</tr>
<tr>
<td>Body mass index (BMI) 22.0–22.9, adult</td>
<td>Z68.22</td>
</tr>
<tr>
<td>Body mass index (BMI) 23.0–23.9, adult</td>
<td>Z68.23</td>
</tr>
<tr>
<td>Body mass index (BMI) 24.0–24.9, adult</td>
<td>Z68.24</td>
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<tr>
<td>Body mass index (BMI) 25.0–25.9, adult</td>
<td>Z68.25</td>
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<tr>
<td>Body mass index (BMI) 26.0–26.9, adult</td>
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<tr>
<td>Body mass index (BMI) 27.0–27.9, adult</td>
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<td>Body mass index (BMI) 28.0–28.9, adult</td>
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<td>Body mass index (BMI) 29.0–29.9, adult</td>
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<td>Body mass index (BMI) 30.0–30.9, adult</td>
<td>Z68.30</td>
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<tr>
<td>Body mass index (BMI) 31.0–31.9, adult</td>
<td>Z68.31</td>
</tr>
<tr>
<td>Body mass index (BMI) 32.0–32.9, adult</td>
<td>Z68.32</td>
</tr>
<tr>
<td>Body mass index (BMI) 33.0–33.9, adult</td>
<td>Z68.33</td>
</tr>
<tr>
<td>Description</td>
<td>ICD-10</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Body mass index (BMI) 34.0-34.9, adult</td>
<td>Z68.34</td>
</tr>
<tr>
<td>Body mass index (BMI) 35.0-35.9, adult</td>
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<td>Body mass index (BMI) 39.0-39.9, adult</td>
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<td>Body mass index (BMI) 40.0-44.9, adult</td>
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<td>Body mass index (BMI) 45.0-49.9, adult</td>
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<tr>
<td>Body mass index (BMI) 50-59.9, adult</td>
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<tr>
<td>Body mass index (BMI) 60.0-69.9, adult</td>
<td>Z68.44</td>
</tr>
<tr>
<td>Body mass index (BMI) 70 or greater, adult</td>
<td>Z68.45</td>
</tr>
<tr>
<td>Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age</td>
<td>Z68.52</td>
</tr>
<tr>
<td>Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age</td>
<td>Z68.53</td>
</tr>
<tr>
<td>Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age</td>
<td>Z68.54</td>
</tr>
</tbody>
</table>
Care for Older Adults

Goal: To increase the percentage of adults 66 years and older who had each of the following during the measurement year.

Measurement Requirements:

• Medication Review
  – Medication list in chart
  – Evidence of a medication review by prescribing provider or clinical pharmacist
  – Date on which medication review was performed

• Functional Status Assessment
  – Complete functional status exam: Cognitive, Ambulation status, Sensory ability Functional independence
  – Date it was performed

• Pain Assessment
  – Pain screening assessment
  – Date it was performed

• Advanced Care Planning
  – Presence of advanced care plan in record OR
  – Documentation of advanced care planning discussion and date performed OR
  – Notation of previously executed advanced care plan

Tips: Care for Older Adults has four separate components that require yearly documentation.

Medication Review - Documentation of at least one complete annual review of patient’s medications and the date when it was performed.

1. Evidence of a medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the date when it was performed
   
   AND

2. Presence of a medication list in the medical record OR a notation that the member is not taking any medication and the date when it was noted

\[\text{Documentation must come from the same medical record and must include prescription and non-prescription medications, vitamins and supplements.}\]

Functional Status Assessment - Documentation of at least one complete functional status assessment during the measurement year and the date when it was performed.
Notations for a complete functional status assessment must include **ONE** of the following:

1. Activities of Daily Living (ADL) were assessed or at least **FIVE** of the following were assessed, including, but not limited to: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.

   **OR**

2. Instrumental Activities of Daily Living (IADL) were assessed or at least **FOUR** of the following were assessed, including, but not limited to: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.

   **OR**

3. Notation that at least **THREE** of the following four components were assessed:
   - Cognitive status
   - Ambulation status
   - Hearing, vision and speech (i.e., sensory ability; all three areas must be assessed)
   - Other functional independence (e.g., exercise, ability to perform job)

   **OR**

4. There are also a number of standardized assessment tools available, not limited to:
   - SF-36*
   - Assessment of Living Skills and Resources (ALSAR)
   - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
   - Bayer ADL (B-ADL) Scale
   - Barthel Index
   - Extended ADL (EADL) Scale
   - Independent Living Scale (ILS)
   - Katz Index of Independence in ADL
   - Kenny Self-Care Evaluation
   - Klein-Bell ADL Scale
   - Kohlman Evaluation of Living Skills (KELS)
   - Lawton & Brody’s IADL scales
   - Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales

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.

**Pain Assessment** - Documentation of at least one pain assessment during the measurement year and 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).

  **OR**

- Result of assessment using a standardized pain assessment tool, not limited to:
  - Numeric rating scales (verbal or written)
  - Face, Legs, Activity, Cry Consolability (FLACC) scale
  - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory)
  - Pain Thermometer
  - Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale)
Notation of a pain management plan alone does not meet criteria. Notation of a pain treatment plan alone does not meet criteria. Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.

**Advanced Care Planning** - Annual discussion about preferences for resuscitation, life-sustaining treatment and end of life care.

**Evidence of advanced care planning must include ONE of the following:**

- The presence of an advanced care plan (advanced directive, living will, actionable medical orders or name of surrogate decision maker) in the medical record
  
  **OR**
  
  - Documentation of an advanced care planning discussion with the provider and the date it was discussed in the measurement year
    
  **OR**
  
  - Notation that the member previously executed and advanced care plan

<table>
<thead>
<tr>
<th><strong>Category II F-codes for Tracking Performance Measures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>Medication Review</td>
</tr>
<tr>
<td>Functional Status Assessment</td>
</tr>
<tr>
<td>Pain Screening</td>
</tr>
<tr>
<td>Advanced Directive present in chart</td>
</tr>
<tr>
<td>Advanced Care Planning Discussion</td>
</tr>
</tbody>
</table>
Osteoporosis Management in Women who had a Fracture

Goal: To increase the percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

To achieve this goal, on a monthly basis Mercy Care Advantage:

- Sends noncompliant, member specific bone mineral density test order forms to Primary Care Providers, requesting a signature, completion of the order form, and return of the order form.
- Call staff outreaches to members when signed BMD test order forms are received and assist in scheduling the BMD test for the member.
- Sends member educational mailing providing education on prevention and treatment of osteoporosis.
- Sends a courtesy notice to Specialists that were seen following the fracture, informing a BMD test has been requested from the members Primary Care Provider.

Tips:

- Fractures of finger, toe, face and skull are not included in this measure.
- 12 month (1 year) window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.
- Make a follow up call if the member is noncompliant after receiving an order for a BMD test or prescription for treating osteoporosis.

<table>
<thead>
<tr>
<th>CPT</th>
<th>HCPCS</th>
<th>ICD10PCS</th>
<th>IDC9PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>76977, 77078, 77080, 77081, 77082, 77085</td>
<td>G0130</td>
<td>BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PPZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BRO7ZZ1, BRO9ZZ1, BROGZZ1</td>
<td>88.98</td>
</tr>
</tbody>
</table>
## Medications on Current Formulary for Treatment of Osteoporosis

### Metabolic Bone Disease Agents—Drugs to Treat Bone Loss

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>alendronate sodium soln</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>alendronate sodium tabs 5mg, 10mg, 40mg</td>
<td>Generic</td>
<td>Quantity Limit (30 EA per 30 days)</td>
</tr>
<tr>
<td>alendronate sodium tabs 35mg, 70mg</td>
<td>Generic</td>
<td>Quantity Limit (4 EA per 28 days)</td>
</tr>
<tr>
<td>calcitonin (salmon)</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>Forteo</td>
<td>Other</td>
<td>Quantity Limit (2.4 ML per 28 days), Prior authorization</td>
</tr>
<tr>
<td>Miacalcin inj</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Prolia</td>
<td>Other</td>
<td>Quantity Limit (1 ML per 180 days)</td>
</tr>
<tr>
<td>risedronate sodium dr</td>
<td>Generic</td>
<td>Quantity Limit (4 EA per 28 days)</td>
</tr>
<tr>
<td>risedronate sodium tabs 35mg</td>
<td>Generic</td>
<td>Quantity Limit (12 EA per 84 days)</td>
</tr>
<tr>
<td>risedronate sodium tabs 30mg, 5mg</td>
<td>Generic</td>
<td>Quantity Limit (30 EA per 30 days)</td>
</tr>
<tr>
<td>risedronate sodium tabs 150mg</td>
<td>Generic</td>
<td>Quantity Limit (1 EA per 28 days)</td>
</tr>
<tr>
<td>zoledronic acid inj 4mg/5ml, 4mg, 5mg/100ml</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>Xgeva</td>
<td>Other</td>
<td>Prior Authorization</td>
</tr>
</tbody>
</table>

### Selective Estrogen Receptor Modifying Agents

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>raloxifene hcl 60 mg tabs</td>
<td>Generic</td>
<td></td>
</tr>
</tbody>
</table>
Bone Mineral Density Test Form below, is an example of a document that will be sent on a monthly basis to Primary Care Providers for members that are in need of a Bone Mineral Density Test.

Bone Mineral Density Test Order Form

Member Name: 
DOB: 
ID Number: 
Telephone Number: 

Please sign below to complete the bone mineral density test order for this member:

<table>
<thead>
<tr>
<th>Primary Care Provider (PCP) Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Signature:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>PCP Phone Number:</td>
</tr>
</tbody>
</table>

If the above order form is not signed, please select or indicate reason why in space provided below. Please return signed and unsigned order forms via fax.

☐ I wish to contact the member myself and order the bone mineral density test.

☐ The member already had a bone mineral density test. If this item is checked, please indicate date of bone mineral density test and send documentation. Date of test: __________

☐ The member has a bone mineral density test appointment scheduled on: ________________

☐ The member was prescribed a drug to treat or prevent osteoporosis on: ________________

☐ This member is not my patient.

☐ Other: __________________________________________________________________________
Comprehensive Diabetes Care

Goal: To increase the percentage of adults 18-75 years with diabetes (type 1 and type 2) that had each of the following during the measurement year.

- Eye Exam
- Kidney Disease Monitoring
- Blood Sugar Controlled

Diabetes Care - Eye Exam

Eye exam (Retinal) performed to check for damage from diabetes

1) With no evidence of retinopathy for one or more annual retinal or dilated eye exams, then exams every 2 years may be considered.

2) With evidence of retinopathy - A retinal or dilated eye exam by an eye care professional at least every year.

Diabetes Care - Kidney Disease Monitoring - A nephropathy screening or monitoring test or evidence of medical attention for nephropathy during the measurement year.

1) A Nephropathy Screening or Monitoring Test - at least yearly - A urine protein test, whether spot, random, timed or 24 hour - any of the following meet criteria:
   a. Albumin
   b. Microalbumin
   c. Protein
   d. Albumin/Creatinine
   e. Protein/Creatinine
   f. Microalbumin/Creatinine
   g. Microalbumin/Protein

   OR

2) Medical Attention for Nephropathy - at least yearly - any of the following meet criteria:
   a. Use of ACE inhibitors/ARB therapy
   b. Documentation of a visit to a nephrologist
   c. Documentation of a renal transplant
   d. Documentation of medical attention for any of the following:
      i. Diabetic Nephropathy
      ii. Chronic Renal Failure
      iii. Acute Renal Failure
      iv. Proteinuria
      v. Renal Dysfunction
      vi. End-Stage Renal Disease
      vii. Renal Insufficiency
      viii. Dialysis (hemodialysis/peritoneal)
      ix. Albuminuria
      x. Chronic Kidney Disease
Diabetes Care - Blood Sugar Controlled - The most recent HbA1c level in the measurement year shows average blood sugar is under control.

1. HbA1c testing with good control (less than 7%). The American Diabetes Association recommends this test is done at least two times every year for those meeting goal, four times a year for those not meeting goal.

2. A less stringent A1C goal, less than 8%, may be appropriate for members with an age of 65 years or more or with a history of Coronary Artery Bypass Graft, Percutaneous Coronary Intervention, Ischemic Vascular Disease, Thoracic Aortic Aneurysm, Chronic Heart Failure, prior Myocardial Infarction, End-Stage Renal Disease, Chronic Kidney Disease, Dementia, Blindness or Amputation (lower extremity).

<table>
<thead>
<tr>
<th>Lab Result</th>
<th>CPT II</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;7%</td>
<td>3044F</td>
</tr>
<tr>
<td>7.0% - 9.0%</td>
<td>3045F</td>
</tr>
<tr>
<td>&gt;9.0%</td>
<td>3046F</td>
</tr>
</tbody>
</table>
Controlling Blood Pressure

Goal: Increase the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) within the first six months of the measurement year AND whose BP was adequately controlled during the measurement year based upon the following criteria:

- Members 18–59 years of age whose BP was <140/90
- Members 60–85 years of age with a co-morbid diagnosis of diabetes whose BP was <140/90
- Members 60–85 years of age without a co-morbid diagnosis of diabetes whose BP was <150/90

The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension was made) is used for this measure. Compliance is based on medical chart reviews.

Tips to improve compliance include:

- Retake the blood pressure if elevated - HEDIS accepts the lowest BP recorded
- Ensure that the BP cuff is the correct size for the patient’s arm
Rheumatoid Arthritis Management

Goal: To increase the percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

<table>
<thead>
<tr>
<th>Codes to Identify Diagnosis of Rheumatoid Arthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>M05.00-M06.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Codes to Identify Exclusions</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>B20, Z21</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>O00.0-O9A53, Z03.71-Z36</td>
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</table>
### Medications on Current Formulary for Treatment of Rheumatoid Arthritis

<table>
<thead>
<tr>
<th>5-Aminosalicylates</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sulfasalazine tabs</td>
<td>Generic</td>
<td></td>
</tr>
</tbody>
</table>

### Monoclonal Antibody

<table>
<thead>
<tr>
<th>Monoclonal Antibody</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rituxan (rituximab)</td>
<td>Generic</td>
<td>Prior Auth</td>
</tr>
</tbody>
</table>

### Immune Suppressants

<table>
<thead>
<tr>
<th>Immune Suppressants</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azathioprine tabs</td>
<td>Generic</td>
<td>Covered under Medicare B or D</td>
</tr>
<tr>
<td>Cimzia</td>
<td>Other</td>
<td>Prior Auth (6 ea per 28 days)</td>
</tr>
<tr>
<td>Cimzia starter kit</td>
<td>Other</td>
<td>Prior Auth (6 ea per 28 days)</td>
</tr>
<tr>
<td>Cellcept intravenous</td>
<td>Other</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Cellcept susr</td>
<td>Other</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Cyclosporine modified</td>
<td>Generic</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Cyclosporine inj</td>
<td>Generic</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Cyclosporine caps</td>
<td>Generic</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Gengraf caps</td>
<td>Other</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Gengraf soln</td>
<td>Other</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Humira (adalimumab)</td>
<td>Other</td>
<td>Prior Auth (6 ea per 28 days)</td>
</tr>
<tr>
<td>Mycophenolate mofetil</td>
<td>Generic</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Remicade (infliximab)</td>
<td>Other</td>
<td>Prior Auth</td>
</tr>
<tr>
<td>Sandimmune soln</td>
<td>Other</td>
<td>Prior Auth</td>
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### Alkylating Agents

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<th>Alkylating Agents</th>
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<th>Requirements/Limits</th>
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</thead>
<tbody>
<tr>
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<td>Generic</td>
<td></td>
</tr>
<tr>
<td>Cyclophosphamide caps</td>
<td>Generic</td>
<td>Covered under Medicare B or D</td>
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</table>

### Anti-Rheumatic

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<tr>
<th>Anti-Rheumatic</th>
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<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuprimine</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Depen titratabs</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Methotrexate sodium</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>Leflunomide</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>Otrexup</td>
<td>Other</td>
<td>Step Therapy</td>
</tr>
<tr>
<td>Rasuvo</td>
<td>Other</td>
<td>Step Therapy</td>
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</table>

### Tetracyclines

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>minocycline hcl caps</td>
<td>Generic</td>
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</table>

### Aminoquinolines

<table>
<thead>
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<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>hydroxychloroquine sulfate tabs</td>
<td>Generic</td>
<td></td>
</tr>
</tbody>
</table>
Rheumatoid Arthritis: Key Priorities for Implementation

Referral for specialist treatment
• Refer for specialist opinion any person with suspected persistent synovitis of undetermined cause.
• Refer urgently if any of the following apply:
  – The small joints of the hands or feet are affected
  – More than one joint is affected
  – There has been a delay of 3 months or longer between onset of symptoms and seeking medical advice

Disease-modifying and biological drugs
In people with newly diagnosed active RA, offer a combination of disease-modifying antirheumatic drugs (DMARDs) (including methotrexate and at least one other DMARD, plus short term glucocorticoids) as first-line treatment as soon as possible, ideally within 3 months of the onset of persistent symptoms.

In people with newly diagnosed RA, for whom combination DMARD therapy is not appropriate¹, start DMARD monotherapy, placing greater emphasis on fast escalation to a clinically effective dose rather than on the choice of DMARD.

In people with recent-onset RA receiving combination DMARD therapy and in whom sustained and satisfactory levels of disease control have been achieved, cautiously try to reduce drug doses to levels that still maintain disease control.

Monitoring disease
• In people with recent-onset active RA, measure C-reactive protein (CRP) and key components of disease activity (using a composite score such as DAS28) monthly until treatment has controlled the disease to a level previously agreed upon with the person with RA.

Multidisciplinary team
• People with RA should have access to a named member of the multidisciplinary team (MDT) (for example, the specialist nurse) who is responsible for coordinating their care.

¹ For example, because of comorbidities or pregnancy, during which certain drugs would be contraindicated.
Reducing the Risk of Falling

This measure is collected using survey methodology, Medicare Health Outcomes Survey (HOS).

Two-part Goal:

• **Discussing Fall Risk** - To increase the percentage of Medicare members 75 years of age and older or 65–74 years of age with balance or walking problems or a fall in the past 12 months, who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.

• **Managing Fall Risk** - To increase the percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.

Cohort 15 Follow-up Data collection (2014) and Cohort 17 Baseline data collection (2014)

---

**Q 48.** A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?

- Yes
- No
- I had no visits in the past 12 months

**Q 49.** Did you fall in the **past 12 months**?

- Yes
- No

**Q 50.** In the **past 12 months** have you had a problem with balance or walking?

- Yes
- No

**Q 51.** Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:

- Suggest that you use a cane or walker
- Check your blood pressure lying or standing
- Suggest that you do an exercise or physical therapy program
- Suggest a vision or hearing testing

- Yes
- No
- I had no visits in the past 12 months
Plan All Cause Readmissions

Goal: To decrease the number of members who have an acute inpatient stay followed by an acute readmission for any diagnosis within 30 days.

Tips to reduce readmission following discharge:

Ensure the member

- Has an appointment with you within 7 days of their discharge date
- Understands and follows their discharge instructions
- Has had their medications reviewed and reconciled with you
- Is following an appropriate diet
- Is utilizing any in-home medical and/or monitoring equipment
- Understands that if they are experiencing symptoms or pain they should immediately escalate their concerns for clinical evaluation
- Is referred to an appropriate level of care for alcohol or drug dependence within 14 days of diagnosis, if applicable
- Has scheduled the necessary follow-up appointments with relevant healthcare providers and has transportation to the appointments
Member Experience with the Health Plan Measures

The following measures are all collected using survey methodology. Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan surveys.

**Getting Needed Care** - How easy it was for a member to get needed care and see specialists.
- In the last 6 months, how often was it easy to get appointments with specialists?
- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?

**Getting Appointments and Care Quickly** - How quickly members get appointments and care.
- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor’s office or clinic as soon as you thought you needed?
- In the last 6 month, how often did you see the person you came to see within 15 minutes of your appointment time?

**Customer Service** - How easy it is for members to get information and help from the plan when needed.
- In the last 6 months, how often did your health plan’s customer service give you the information or help you needed?
- In the last 6 months, how often did your health plan’s customer service treat you with courtesy and respect?
- In the last 6 months, how often were the forms for your health plan easy to fill out?
Rating of Health Care Quality - Score the plan earned from members who rated the quality of the health care they received.

- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

Rating of Health Plan - Score the plan earned from members who rated the health plan.

- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Care Coordination - Score the plan earned on how well the plan coordinates members’ care. This score is comprised of the results from a variety of questions regarding:

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor’s office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor’s office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
Non-Recommended PSA-Based Screening in Older Men (PSA)

Goal: To decrease the percentage of men 70 and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening.

*A lower rate indicates better performance.*
Pharmacotherapy Management of COPD Exacerbation (PCE)

Goal: To increase the percentage of members 40 years of age and older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement year and who were dispensed appropriate medications.

Two rates are reported:
1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.

AND

2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Tips: Assess potential barriers before selecting the appropriate medications.
- **Financial barriers:**
  - Are there financial barriers that are going to prevent the member from filling the prescribing medications?
- **Knowledge deficit on how to properly use an inhaler:**
  - Does the member feel confident and comfortable on how to properly use their prescribed inhalers?
- **Knowledge deficit on indications for inhalers:**
  - Does the member understand the importance of why they are prescribed the medications and the importance of taking exactly as prescribed?
  - Does the member understand when to use their prescribed medications?

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>J44.0, J44.1, J44.9</td>
</tr>
<tr>
<td>Emphysema</td>
<td>J43.0-J43.2, J43.8, J43.9</td>
</tr>
<tr>
<td>Chronic Bronchitis</td>
<td>J41.0, J41.1, J41.8, J42</td>
</tr>
</tbody>
</table>
### Medications on Current Formulary for Treatment of COPD Exacerbation

#### Glucocorticoids
<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexamethasone Intensol</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>dexamethasone sodium phosphate inj 10mg/ml, 4mg/ml, 120mg/30ml, 100mg/10ml, 10mg/ml, 20mg/5ml</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>dexamethasone elix, soln, tabs</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>methylprednisolone sodium succinate</td>
<td>Generic</td>
<td></td>
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<td>methylprednisolone dose pack</td>
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<tr>
<td>methylprednisolone tabs</td>
<td>Generic</td>
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</tr>
<tr>
<td>prednisolone acetate</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>prednisolone (as sodium phosphate) 5mg/5ml, 15mg/5ml, 25mg/5ml</td>
<td>Generic</td>
<td></td>
</tr>
<tr>
<td>Millipred</td>
<td>Other</td>
<td></td>
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<tr>
<td>Millipred DP</td>
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<tr>
<td>prednisolone soln, syrp, tabs</td>
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<td></td>
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<tr>
<td>a-hydrocort</td>
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</table>

#### Anticholinergic/Beta Agonist Combinations
<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combivent Respimat</td>
<td>Other</td>
<td>QL (8GM per 30 days)</td>
</tr>
<tr>
<td>ipratropium bromide/albuterol sulfate</td>
<td>Generic</td>
<td>Covered under Medicare B or D</td>
</tr>
<tr>
<td>ipratropium bromide inhalation soln</td>
<td>Generic</td>
<td>Covered under Medicare B or D</td>
</tr>
<tr>
<td>Spiriva Respimat</td>
<td>Other</td>
<td>QL (4 GM per 30 days)</td>
</tr>
<tr>
<td>Spiriva Handihaler</td>
<td>Other</td>
<td>QL (30 EA per 30 days)</td>
</tr>
</tbody>
</table>

#### Methylxanthines
<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>aminophylline</td>
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</tr>
<tr>
<td>theophylline, er</td>
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#### Beta 2- Agonists
<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug Tier</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proair HFA</td>
<td>Other</td>
<td>QL (17 GM per 30 days)</td>
</tr>
<tr>
<td>Proair Respíclick</td>
<td>Other</td>
<td>QL (2 EA per 30 days)</td>
</tr>
<tr>
<td>Ventolin HFA</td>
<td>Other</td>
<td>QL (36 GM per 30 days)</td>
</tr>
<tr>
<td>Advair Diskus</td>
<td>Other</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>Advair HFA</td>
<td>Other</td>
<td>QL (12 GM per 30 days)</td>
</tr>
<tr>
<td>Breo Ellipta</td>
<td>Other</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>Arcapta Neohaler</td>
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</tr>
<tr>
<td>Striverdi Respimat</td>
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</tr>
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<td>Stiolto Respimat</td>
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<td>QL (4 GM per 30 days)</td>
</tr>
<tr>
<td>Amoro Ellipta</td>
<td>Other</td>
<td>QL (60 EA per 30 days)</td>
</tr>
<tr>
<td>albuterol Sulfate tabs, syrp</td>
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<td></td>
</tr>
<tr>
<td>albuterol Extended Release</td>
<td>Generic</td>
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<tr>
<td>albuterol Nebu</td>
<td>Generic</td>
<td>Covered under Medicare B or D</td>
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<tr>
<td>metaproterenol Sulfate tabs, syrp</td>
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</tr>
<tr>
<td>levalbuterol nub</td>
<td>Generic</td>
<td>Covered under Medicare B or D</td>
</tr>
</tbody>
</table>
Pneumococcal Vaccination Status for Older Adults (PNU)

This measure is collected using survey methodology. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.

Measure: Pneumonia Vaccine - Percentage of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator).

Goal: To increase the percentage of Medicare members 65 years of age and older who have ever received a pneumococcal vaccine.

Eligible population: 65 years and older as of January 1 of the measurement year.

CAHPS Survey Question
Q: Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person’s lifetime and is different from a flu shot. It is also called the pneumococcal vaccine.
Medication Reconciliation Post-Discharge (MRP)

Goal: To increase the percentage of discharges during the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.

A Medication Reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. This reconciliation may be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse, as documented in the outpatient chart on or within 30 days of discharge.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>Medication Review</td>
<td>90863, 99605, 99606</td>
<td>1159F, 1160F</td>
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<tr>
<td>TCM 7 day</td>
<td>99496</td>
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</tr>
<tr>
<td>TCM 14 day</td>
<td>99495</td>
<td></td>
</tr>
</tbody>
</table>
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Goal: To increase percentage of adolescent (13–17 years of age) and adult (18 years of age and over) members with a new episode of alcohol or other drug (AOD) dependence who received the following.

- **Initiation of AOD Treatment**: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

- **Engagement of AOD Treatment**: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Provider Manual
Chapter 6 - Behavioral Health

6.0 - Behavioral Health Overview
MCA covers behavioral health services under certain conditions that include:

- Partial hospital program and intensive outpatient programs
- Medication monitoring
- Counseling by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. (First ten visits are covered without Prior Authorization for contracted providers)
- Inpatient psychiatric services with a limitation on freestanding psychiatric hospitals. There is a 190 day limit for free standing psychiatric hospitals. If the enrollee goes to a behavioral health unit contained in the hospital this limit does not apply.
- Substance Abuse Treatment - Substance abuse mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant or other Medicare-qualified mental health care professional as allowed under applicable state laws

6.1 - MCA Behavioral Health Emergency Services
If an enrollee is in a behavioral health crisis, call the MCA Behavioral Health Hotline at: 800-876-5835. Medicare covers medically necessary services. MCA enrollees are eligible for behavioral health services through contracted behavioral health providers.

6.2 - PCP Responsibilities for MCA Care Behavioral Health Services
Enrollees should be screened by their PCP for behavioral health needs during routine or preventive visits. If a provider feels that an enrollee needs behavioral health services, referrals for these services should be coordinated through the enrollee’s case manager for long term care enrollees and the behavioral health coordinator for acute plan enrollees.

6.3 - Coordination of Care
The PCP will be informed of the enrollee’s behavioral health provider so that communication may be established. It is very important that PCPs develop a strong communication link with the behavioral health provider. PCPs are expected to exchange any relevant information such as medical history, current medications, current behavioral health diagnosis and treatment within 10 business days of receiving the request.

Where there has been a change in an enrollee’s health status identified by a medical provider, there should be coordination of care with the behavioral health provider within a timely manner. The update should include but is not limited to; diagnosis of chronic conditions, support for the petitioning process, and all medication prescribed.

The PCP should also document and initial signing review receipt of information received from a behavioral health provider who is treating the enrollee.

The behavioral health providers should supply the PCP with information regarding services that they are providing so that they may be included in the enrollee’s permanent medical record.
Forms
Missed appointment log

In an effort to improve our member’s health and assist your office with missed and “No Show” appointments, please fill in the requested information for Mercy Care Advantage members only. With this information, our outreach staff can call each member to offer assistance with issues that may be hindering the member from keeping their appointments, such as transportation. Please notify Mercy Care Advantage within one week of the appointment by faxing this form to 1-860-907-3430. If you have any questions, please call 602-361-9194.

<table>
<thead>
<tr>
<th>Member ID #</th>
<th>Member name</th>
<th>Missed appointment date and time</th>
<th>Late and not seen</th>
<th>No show</th>
<th>Cancelled &lt;24 hrs.</th>
<th>Reason for appointment</th>
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This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.
Member’s PCP Change Request Form

I, _____________________________ am requesting to be assigned to the following Primary Care Physician (PCP): ____________________________ effective ____________________.

I understand it is my choice to select a PCP, and I am freely requesting this change be processed on my behalf by ____________________________ personnel. I have recorded my information below to confirm my identity.

Member’s Name: ________________________________________________________________

Date of Birth: ______________________ AHCCCS ID number: __________________________

Mailing Address: ________________________________________________________________

Contact Telephone Number: ______________________________________________________

Member’s Signature: ____________________________ Date: ____________________________

Witness Name: ____________________________ Date: ____________________________

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For Office Use Only

Demographic Information of Group Requesting Change

Group Name: __________________________________________________________________

Address: ______________________________________________________________________

Tax Id Number: __________________________________________________________________

PCP Information

PCP’s Name: ___________________________________________________________________

Physical Address (Location): ______________________________________________________

PCP’s Individual NPI: _____________________________________________________________

Office Staff Name (Print): ____________________________ Date: ______________________

Email Request to: MBU-MCP_Enrollment@AETNA.com or
FAX Request to: 602-351-2313
# PROVIDER ASSISTANCE PROGRAM

**IMPORTANT INSTRUCTIONS:** The purpose of the *Provider Assistance Program* is to help providers coordinate and/or manage the medical care for Mercy Care Plan members at risk. Please complete this form and fax or mail it to member services (fax # 602 351-2313).

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID#:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Provider Address:</td>
<td></td>
</tr>
<tr>
<td>Provider City, State, Zip</td>
<td></td>
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<tr>
<td>Provider Phone Number:</td>
<td></td>
</tr>
<tr>
<td>Contact Person</td>
<td></td>
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</tbody>
</table>

Check box for member assignment (PCPs only) and select primary reason for requesting assistance

- [ ] Continue Member Assignment
- [ ] Remove Member From Panel (Include member 30 day discharge notice - *A removal will not be processed without the Member Discharge Letter.*

**Member Issue:**
- [ ] Communication/Deteriorated Relationship (PR01)
- [ ] Excessive No-Shows (PR04)
- [ ] Complex Medical Care/different doctor needed (PR07)
- [ ] Non-Compliant with Medical Care (PR05)
- [ ] (Case Management Needed)
- [ ] Possible Drug Seeking (PR06)
- [ ] Possible Fraud (PR08)
- [ ] Other (Describe below) (PROT)

Briefly describe the problem:

Provider Signature: ____________________________  Date: ____________

**Office Use only:** LOB_______  MSR_______

- [ ] Changed PCP
- [ ] Referred for No Show f/u
- [ ] Referred for Rx restriction
- [ ] Referred to CM
- [ ] Completed Fraud Form
- [ ] No Action Taken

Revised: November 2014
Quick Reference Guide-
Appointment Availability Standards

**Primary Care**

<table>
<thead>
<tr>
<th>Type</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td>EMERGENCY</td>
<td>Same day of request or within 24 hours of call or notification</td>
</tr>
<tr>
<td>URGENT</td>
<td>Within 2 days of request</td>
</tr>
<tr>
<td>ROUTINE</td>
<td>Within 21 days of request</td>
</tr>
</tbody>
</table>

**Specialty Care**

<table>
<thead>
<tr>
<th>Type</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY</td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td>URGENT</td>
<td>Within 3 days of referral</td>
</tr>
<tr>
<td>ROUTINE</td>
<td>Within 45 days of referral</td>
</tr>
</tbody>
</table>

**Dental Care**

<table>
<thead>
<tr>
<th>Type</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY</td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td>URGENT</td>
<td>Within 3 days of referral</td>
</tr>
<tr>
<td>ROUTINE</td>
<td>Within 45 days of referral</td>
</tr>
</tbody>
</table>

**Maternity Care**

<table>
<thead>
<tr>
<th>Trimester</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td>FIRST</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>SECOND</td>
<td>Within 7 days of request</td>
</tr>
<tr>
<td>THIRD</td>
<td>Within 3 days of request</td>
</tr>
<tr>
<td>HIGH RISK PREGNANCIES</td>
<td>Within 3 days of identification of High Risk</td>
</tr>
</tbody>
</table>

**Wait Time**

Should not be more than 45 minutes from appointment time (except if provider is unavailable due to an emergency).