Provider Newsletter

https://provider.simplyhealthcareplans.com/florida-provider

October 2019

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Simply Healthcare Plans, Inc. is a Managed Care Plan with a Florida Medicaid contract.

Pharmacy benefit manager change to IngenioRx

Effective October 1, 2019, IngenioRx will become the pharmacy benefit manager (PBM) for prescription drugs, home delivery pharmacy and specialty pharmacy for Simply Healthcare Plans, Inc. (Simply) members.

Transferring prescriptions

We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using home delivery through Express Scripts Mail Order Pharmacy. For patients receiving specialty drugs from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Patients filling prescriptions at a retail pharmacy can continue, in most cases, using their same retail pharmacy.

Prescriptions for controlled substances or compounded drugs currently being filled at Express Scripts Mail Order Pharmacy or other out of network mail order pharmacy, Accredo or other out of network specialty pharmacies cannot be transferred to another pharmacy under federal law. Patients currently receiving these medications will need a new prescription sent to an IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.

More information coming soon

We will send additional information from Simply regarding this transition to the new PBM.

If you have questions about this change, contact your local Provider Relations representative or call Provider Services at **1-844-405-4296**.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.
IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Simply Healthcare Plans, Inc.

SFL-NL-0033-19

Evaluation and management services — over-coded services

In an ongoing effort to ensure accurate claims processing and payment, Simply Healthcare Plans, Inc. (Simply) is taking additional steps to verify the accuracy of payments made to providers. Beginning on October 27, 2019, Simply will assess selected claims for evaluation and management (E&M) services using an automated analytic solution to ensure payments are aligned with national industry coding standards.

Providers should report E&M services in accordance with the American Medical Association CPT® manual and CMS guidelines for billing E&M service codes (**Documentation Guidelines for Evaluation and Management**).

The level of service for E&M service codes is based primarily on the documented key factors, medical history, examination and medical decision-making. Counseling, coordination of care, the nature of the presenting problem and face-to-face interaction are considered contributing factors. The appropriate E&M level code should reflect and not exceed what is needed to manage the member's condition(s).

Claims will be selected from providers who, based on a risk adjusted analysis, code a higher level of E&M services compared to their peers with similar risk-adjusted members. Individual claims will be identified as over-coded based on a claim specific risk adjusted analysis. If a claim is determined to be over-coded, it will be reimbursed at the fee schedule rate for the appropriate level of E&M for the condition(s) identified. Providers whose coding patterns improve are eligible to be removed from the program.

If providers have medical record documentation to support reimbursement for the originally submitted E&M service, those medical records should be submitted for consideration.

SFL-NL-0062-19

Clinical Criteria updates

Quarter one

On February 22, 2019, and March 14, 2019, the Pharmacy and Therapeutics (P&T) Committee approved changes to *Clinical Criteria* applicable to the medical drug benefit for Simply Healthcare Plans, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates will be reflected in the ***Clinical Criteria* Q1 web posting**.

SFL-NL-0068-19

Quarter two

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Effective dates will be reflected in the ***Clinical Criteria* Q2 update**.

SFL-NL-0066-19

Clinical Criteria is publicly available on our **provider website**. Visit ***Clinical Criteria*** to search for specific policies.

For questions or additional information, use this **email**.

MCG Care Guidelines update and customizations

The upgrade to the 23rd edition of the MCG Care Guidelines for Simply Healthcare Plans, Inc. (Simply) has changed from May 24, 2019, to September 5, 2019. In addition, Simply has customized some of the MCG Criteria.

Customizations to the 23rd edition of the MCG Care Guidelines:

Effective September 5, 2019, the following customizations will be implemented:

- Left Atrial Appendage Closure, Percutaneous (W0157) — customized to refer to SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156) — customized to refer to Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

Effective November 1, 2019, customizations will be implemented for Chemotherapy and Inpatient & Surgical Care (W0162) for adult patients. The customizations provide specific criteria, guidance and/or examples for the following:

- Clinical indications for admission:
  - Aggressive hydration needs that cannot be managed in an infusion center
  - Prolonged marrow suppression
- Regimens that cannot be managed outpatient

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations **online** by selecting Customizations to **MCG Care Guidelines 23rd Edition (Publish date November 1, 2019)**.

SFL-NL-0067-19

Authorization process update for identified HCBS procedure codes

Simply Healthcare Plans, Inc. (Simply) is modifying the authorization process for the following home- and community-based services:

- Personal Care Services: T1019 and T1020
- Personal Care Services — agency: S5125
- Homemaker Service: G9004, G9005 and S5130

The above services will be authorized by Simply for up to a year at a time, broken down into in monthly units (January, February, March, April, May, etc.). This change will not allow unused units from a previous month to be provided and paid without prior authorization approval.

No additional services will be affected by these changes at this time.

Authorizing services with monthly units will:

- Allow easier matching of claims to authorizations.
- Allow case managers to more efficiently track utilized services from month to month, identify gaps in care and more easily make revisions when a member has a change in condition that necessitates service changes.
- Reduce authorization impact when service needs change. Authorizations can be revised for the impacted months only.
- Affect only authorizations for members whose annual service plan is due beginning January 1, 2020.

These changes will not:

- Affect how a provider currently requests or bills for services.
- Impact authorizations for members whose annual service plan is not due.

SFL-NL-0082-19

Simply healthcare

Clinical Criteria updates

View the **article** in the Medicaid section.

SFL-NL-0068-19/SFL-NL-0066-19

Pharmacy benefit manager change to IngenioRx

Effective January 1, 2020, IngenioRx will become our new pharmacy benefit manager (PBM) and will start managing prescription coverage for your Medicare Advantage individual and group retiree plan patients. IngenioRx PBM services will include handling your patients' prescriptions for mail order and specialty pharmacy medications.

Transferring prescriptions

We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using Express Scripts Mail Order Pharmacy. Members will receive instructions for initializing IngenioRx Home Delivery Pharmacy later this year. For patients receiving specialty drugs from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Most patients will be able to fill their prescriptions at their same retail pharmacy outlet. If your patient's pharmacy will not be available, we will notify your patient by letter and include a list of three alternative pharmacies near his or her home.

Prescriptions for controlled substances currently being filled at Express Scripts Mail Order Pharmacy or Accredo cannot be transferred to another pharmacy under federal law. Patients currently receiving these medications will need a new prescription sent to IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.

For providers	Then
Who use ePrescribing	There are no changes — Select IngenioRx.
Who do not use ePrescribing	You should send your mail order and specialty prescriptions to IngenioRx. IngenioRx will begin accepting prescriptions January 1, 2020. Please consider the days' supply of the prescription when making these requests. • IngenioRx Mail Order Pharmacy new prescriptions: – Phone: **1-833-203-1742** – Fax: **1-800-378-0323** • IngenioRx Specialty Pharmacy: – Prescriber phone: **1-833-262-1726** – Prescriber fax: **1-833-263-2871**

You can confirm whether your patient has transitioned to IngenioRx through the Availity Portal. Your patient's PBM information can be located in the Patient Information section of their patient profile as part of the eligibility.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.
IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Simply Healthcare Plans, Inc.

SHPCRNL-0016-19

Simply Healthcare Plans, Inc. is a Medicare-contracted coordinated care plan that has a Medicaid contract with the State of Florida Agency for Health Care Administration to provide benefits or arrange for benefits to be provided to enrollees. Enrollment in Simply Healthcare Plans, Inc. depends on contract renewal.

Clinical Laboratory Improvement Amendments for Simply Health Care Plans, Inc.

Claims that are submitted for laboratory services subject to the *Clinical Laboratory Improvement Amendments of 1988* (*CLIA*) statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid *CLIA* certificate identification number must be reported on a *1500 Health Insurance Claim Form* (*CMS-1500*) or its electronic equivalent effective July 1, 2015. The *CLIA* certificate identification number must be submitted in one of the following manners:

Claim format and elements	*CLIA* number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly HCFA 1500)	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the address is not equal to the billing provider address. The servicing provider address must match the address associated with the *CLIA* ID entered in field 23.
HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the *CLIA* ID submitted in the 2300 loop, REF02.

Providers who have obtained a *CLIA Waiver* or *Provider Performed Microscopy Procedure* accreditation must include the QW modifier when any *CLIA* waived laboratory service is reported on a *CMS-1500* claim form in order for the procedure to be evaluated to determine eligibility for benefit coverage.

Laboratory procedures are only covered and, therefore, payable if rendered by an appropriately licensed or certified laboratory having the appropriate level of *CLIA* accreditation for the particular test performed. Thus, any claim that does not contain the *CLIA* ID, has an invalid ID, has a lab accreditation level that does not support the billed service code and/or does not have complete servicing provider demographic information will be considered incomplete and rejected or denied beginning November 1, 2019.

SHPCRNL-0017-19

Customizations to the 23rd edition of the MCG Care Guidelines

Effective November 1, 2019, customizations will be implemented for Chemotherapy and Inpatient & Surgical Care (W0162) for adult patients. The customizations provide specific criteria and guidance on the following:

- Clinical indications for admission; examples will also be added for:
  - Aggressive hydration needs that cannot be managed in an infusion center.
  - Prolonged marrow suppression.
- Regimens that cannot be managed outpatient; examples will also be added.

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations online by selecting Customizations to **MCG Care Guidelines 23rd Edition**.

SHPCRNL-0018-19

Medicare preferred continuous glucose monitors

On January 1, 2020, Simply Healthcare Plans, Inc. (Simply) will implement a preferred edit on Medicare-eligible continuous glucose monitors (CGMs). Currently, there are two CGM systems covered by CMS under the Medicare Advantage Part D (MAPD) benefit; these are Dexcom and Freestyle Libre. The preferred CGM for Medicare Advantage Part D individual members covered by Simply will be Freestyle Libre. This edit will only affect members who are newly receiving a CGM system. Members will need to obtain their CGM system from a retail or mail order pharmacy – not a durable medical equipment facility. For Dexcom coverage requests, call **1-833-293-0661**.

SHPCRNL-0025-19

Aspire Telehealth Palliative Care program

Aspire Health for Medicare members in need of telephonic palliative care

The Aspire Telehealth Palliative Care program provides an additional layer of telephonic support to patients facing a serious illness. The program is focused on:

- Helping patients understand their diagnosis.
- Facilitating conversations with patients and their families around their goals of care.
- Ensuring patients receive care aligned with their goals and values.

The program begins with an initial 30 to 60 minute telephonic assessment by a specially trained Aspire Health social worker. The conversation in this initial call focuses on building rapport and completing a comprehensive assessment. This assessment includes understanding the patient's perception of their illness and current treatment plan. Follow-up calls occur every 2 to 4 weeks, typically lasting 15 to 45 minutes, with the exact frequency based on a patient's individual need. Aspire Health's social workers are supported by a full interdisciplinary team of board-certified palliative care physicians, nurses, and chaplains who provide additional telephonic support to patients and their families as needed. Patients enrolled in the telehealth program have access to 24/7 on-call support. The average patient is enrolled in the program for 6 to 8 months with some of the key goals being the ability for patients to teach-back their current medical situation, articulate their health and quality-of-life goals, and establish a future care plan through either the completion of advanced care planning documents and/or a transition to hospice when appropriate.

More information is available at **www.aspirehealthcare.com** or by calling the 24/7 Patient & Referral Hotline at **1-844-232-0500**.

Aspire Health is an independent company providing telephonic palliative care on behalf of Simply Healthcare Plans, Inc.

SHPCRNL-0024-19

Medical Policies and *Clinical Utilization Management Guidelines* update

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. For markets with carved-out pharmacy services, the applicable listings below are informational only. Please note: The *Medical Policies* and *Clinical UM Guidelines* below are followed in the absence of Medicare guidance.

To search for specific policies or guidelines, visit **https://medicalpolicy.simplyhealthcareplans.com/shp_search.html**.

March 2019 updates

Updates:

- CG-DME-44 — Electric Tumor Treatment Field was revised to add the use of enhanced computer treatment planning software (such as NovoTal) as not medically necessary (NMN) in all cases.
- CG-MED-72 — Hyperthermia for Cancer Therapy was revised to clarify medically necessary (MN) and NMN statements addressing frequency of treatment.
- CG-SURG-09 — Temporomandibular Disorders was revised to clarify MN and NMN criteria and removed requirement for FDA approval of prosthetic implants.
- CG-SURG-30 — Tonsillectomy for Children With or Without Adenoidectomy was revised to:
  - Spell out number of episodes of throat infections in MN criteria (A1, A2, A3).
  - Clarify criterion addressing parapharyngeal abscess (B4) to say “two or more.”
  - Add “asthma” as potential condition improved by tonsillectomy in MN criteria (C1b).
- GENE.00043 — Genetic Testing of an Individual’s Genome for Inherited Diseases was revised to remove investigational and NMN statement and all other language and coding related to Corus CAD testing. Corus CAD testing is now addressed in GENE.00050.
- The following AIM Specialty Health® updates took effect on September 28, 2019:
  - Advanced Imaging
    - Imaging of the brain
    - Imaging of the extremities
    - Imaging of the spine

Medical Policies

On March 21, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Simply Healthcare Plans, Inc. (Simply). View the full update online for a list of the policies.

Clinical UM Guidelines

On March 21, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Simply. These guidelines were adopted by the medical operations committee for Simply members on May 7, 2019. View the full update online for a list of the guidelines.

SHPCRNL-0015-19

June 2019 updates

Notes/updates

Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive:

- * DME.00037 — added devices that combine cooling and vibration to the investigational and not medically necessary statement
- * LAB.00027 — added Mediator Release Test to investigational and not medically necessary statement
- * LAB.00033 — clarified investigational and not medically necessary statement to include 4Kscore and AR-V7
- * OR-PR.00003:
  - Clarified medically necessary position statement criteria 2 through 4
  - Added statement that use of prosthetic devices that combine both a microprocessor controlled knee and foot-ankle prosthesis is considered investigational and not medically necessary for all indications
- * SURG.00011:
  - Added new medically necessary and investigational and not medically necessary statements addressing amniotic membrane-derived products for conjunctival and corneal indications, including KeraSys and Prokera
  - Added new products to investigational and not medically necessary statement
- * SURG.00045:
  - Added erectile dysfunction, Peyronie's disease and wound repair to the investigational and not medically necessary statement
  - Revised title
- * SURG.00121 — added investigational and not medically necessary statement to address use of transcatheter tricuspid valve repair or replacement for all indications
- The following AIM Specialty Health® updates were approved on June 6, 2019:
  - Advanced imaging:
    - Imaging of the heart
    - Oncologic imaging
    - Vascular imaging
  - Proton beam therapy
  - Rehabilitative therapies — physical therapy, occupational therapy and speech therapy (new)

Medical Policies

On June 6, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Simply Healthcare Plans, Inc. (Simply). View the full update online for a list of the policies.

Clinical UM Guidelines

On June 6, 2019, the MPTAC approved several *Clinical UM Guidelines* applicable to Simply. These guidelines were adopted by the medical operations committee for Simply members on July 5, 2019. View the full update online for a list of the guidelines.

SHPCRNL-0021-19

Prior authorization requirements for continuous positive airway pressure supplies

Effective December 1, 2019, prior authorization (PA) requirements will change for select continuous positive airway pressure (CPAP) supplies.

Clinical hierarchy for medical necessity determination is as noted. For Medicare Advantage products, Simply Healthcare Plans, Inc. (Simply) makes coverage determinations based on CMS national coverage determinations, local coverage determinations, other coverage guidelines and instructions issued by CMS and legislative benefit changes. The *Clinical Guidelines* that have been adopted by Simply to review for medical necessity are also located at **http://www.aimspecialtyhealth.com/marketing/guidelines/185/index.html**.

Prior authorization requirements

For services that are scheduled on or after December 1, 2019, providers must contact Integrated Health Care Services (IHCS), our durable medical equipment partner, to obtain prior authorization for the services detailed below. Providers are strongly encouraged to verify that a prior authorization has been obtained before scheduling and performing services.

- A4604 — Tubing with heating element
- A7046 — Water chamber for humidifier, replacement, each
- A7027 — Combination Oral/Nasal Mask used with positive airway pressure device, each
- A7030 — Full Face Mask used with positive airway pressure device, each
- A7031 — Face Mask Cushion, Replacement for Full Face Mask
- A7034 — Nasal Interface (mask or cannula type), used with positive airway pressure device, with/without head strap
- A7035 — Headgear
- A7036 — Chinstrap
- A7037 — Tubing
- A7039 — Filter, non-disposable
- A7044 — Oral Interface for Positive Airway Pressure Therapy
- A7045 — Replacement Exhalation Port for PAP Therapy
- A7028 — Oral Cushion, Replacement for Combination Oral/Nasal Mask, each
- A7029 — Nasal Pillows, Replacement for Combination Oral/Nasal Mask, pair
- A7032 — Replacement Cushion for Nasal Application Device
- A7033 — Replacement Pillows for Nasal Application Device, pair
- A7038 — Filter, disposable

Federal and state law, as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

Requesting PA

To request PA, you may use one of the following methods:

- Fax: **1-800-964-3627**
- Phone: **1-844-406-2396**

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at **https://www.availity.com**. Contracted and noncontracted providers may call Provider Services at **1-844-405-4297** for prior authorization requirements or additional questions.

SHPCRNL-0020-19

Pharmacy benefit manager change to IngenioRx

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Transferring prescriptions

We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using home delivery through Express Scripts Mail Order Pharmacy. For patients receiving specialty drugs from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Patients filling prescriptions at a retail pharmacy can continue, in most cases, using their same retail pharmacy.

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More information coming soon

We will send additional information from CHA regarding this transition to the new PBM. If you have questions about this change, contact your local Provider Relations representative or call Provider Services at **1-844-405-4296**.

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SFL-NL-0033-19

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SFL-NL-0082-19

CLEAR HEALTH ALLIANCE