

Provider Newsletter



Medicaid Managed Care

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

April 2019



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Practitioners' rights during credentialing process

The credentialing process must be completed before a practitioner begins seeing members and enters into a contractual relationship with a health care insurer. As part of our credentialing process, practitioners have certain rights, as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application.
- Correct erroneous information regarding a credentialing application.
- Be notified of the status of credentialing or recredentialing applications.



The Council for Affordable Quality Healthcare (CAQH®) universal credentialing process is used for individual providers who contract with Amerigroup. To apply for credentialing with Amerigroup, go to the [CAQH website](#) and select **CAQH ProView™**. There is no application fee.

We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members' claims.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

SFL-NL-0011-18/SFL-NL-0035-19

Provider surveys

Each year we reach out to you to ask what we are doing well and how we can continue to improve our services. We use this feedback to continually improve our operations and strengthen our relationship with our providers.



Thank you for participating in our network, for providing quality health care to our members and for your timely completion of any surveys you receive.

SFL-NL-0011-18/SFL-NL-0035-19

Update: evaluation and management with Modifier 25

Simply Healthcare Plans, Inc. (Simply) has identified that providers often bill a duplicate evaluation and management (E&M) service on the same day as a procedure, even when the same provider (or a provider with the same specialty within the same group TIN) recently billed a service or procedure which included an E&M service for the same or similar diagnosis. The use of Modifier 25 to support separate payment of this duplicate service is not consistent with correct coding or Simply policy on use of Modifier 25.

Beginning with claims processed on or after May 1, 2019, Simply may deny the E&M service with a Modifier 25 billed on the day of a related procedure when there is a recent service or procedure for the same or similar diagnosis on record.

If you believe a claim should be reprocessed because there are medical records for related visits that demonstrate an unrelated, significant and separately identifiable E&M service, please submit those medical records for consideration.

SFL-NL-0025-19

Introducing a new *Clinical Criteria* web page for injectable, infused or implanted drugs covered under the medical benefit

Beginning March 1, 2019, providers will be able to view the [Clinical Criteria website](#) to review *Clinical Criteria* for all injectable, infused or implanted prescription drugs.

This new website will provide the *Clinical Criteria* documents for all injectable, infused, or implanted prescription drugs and therapies covered under the medical benefit. These *Clinical Criteria* documents are not yet being used for clinical reviews, but are available to providers for familiarization of the new location and formatting.

Once finalized, providers will be notified prior to implementation of *Clinical Criteria* documents. Injectable oncology drug *Clinical Criteria* will not be posted on this website until mid-2019. Until implementation, providers should continue to access the *Clinical Criteria* for medications covered under the medical benefit through the standard process.

If you have questions or feedback, please use this [email](#) link.

SCFL-NL-0004-18



Clinical Criteria updates

On August 17, 2018, October 9, 2018, and November 16, 2018, the pharmacy and therapeutic (P&T) committee approved *Clinical Criteria* applicable to the medical drug benefit for Simply Healthcare Plans, Inc. (Simply). These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the Simply provider website, and the effective dates are reflected in the [Clinical Criteria updates notification](#). Visit the [Clinical Criteria website](#) to search for specific policies.

[Email](#) for questions or additional information.

SFL-NL-0031-19

Help prevent preeclampsia with prenatal aspirin

Preeclampsia is one of four types of hypertensive disorders of pregnancy. It is defined as the development of hypertension with either proteinuria or end-organ dysfunction with onset after 20 weeks of gestation in a previously normotensive woman.

Preeclampsia facts:

- The exact incidence of preeclampsia is unknown.
- Preeclampsia is reported to affect 5-10 percent of pregnancies, with rates in the United States increasing (*ACOG Comm Op #638*, September 2015, Reaffirmed, 2017).
- Preeclampsia is one of the leading causes of maternal morbidity and mortality, accounting for 15.9 percent of the approximately 700 pregnancy-related deaths in the United States.
- Non-Hispanic Black women experience mortality rates 3-4 times that of non-Hispanic White women (*CDC Advancing the Health of Mothers in the 21st Century At A Glance*, 2016).

Tips for providers:

- Prenatal aspirin and home blood pressure monitors are covered benefits for our members.
- Prescriptions for aspirin avoid out-of-pocket costs for members.
- Prescriptions for automatic, digital, home-use blood pressure monitors (with appropriately sized cuffs), along with proper instruction encourage members to identify preeclampsia early.
- Education on normal blood pressure range during pregnancy empowers members to partner with you in their prenatal care.



[Read more online.](#)

SFL-NL-0030-19

Coding Spotlight: Cancer

A provider's guide to properly code cancers

Cancer is often coded inaccurately, and there are missed opportunities to show which patients are sicker and are at a higher risk and those that are no longer being treated for this chronic condition.

Documentation and coding of neoplasms has proven over time to be a source of many errors, including incorrect assignment of the morphology of the diagnosis and active cancer versus historical cancer. Neoplasms are classified in ICD-10-CM by anatomical location and morphology. It is essential to document the specific site of cancer and laterality. Words like "mass", "lump" and "tumor" should be avoided if more specific language is available. If known, the behavior of the neoplasm should be documented, such as benign, primary malignant, secondary malignant, in situ or uncertain.

"History of malignant neoplasm" or "no evidence of disease" should not be documented if the neoplasm is still being actively treated. Instead, the continuation of care should be documented, noting what has been done and what is left to do.

"History of" and "no evidence of disease" indicate an eradicated condition and a complete cure, according to coding guidelines, and would result in a history of malignant neoplasm code instead of an active malignant neoplasm code.



[Read more online.](#)

SFL-NL-0021-18

Medicare Advantage

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SFL-NL-0025-19

Simply Healthcare Plans, Inc. Medicare Advantage HMO is now NCQA accredited

The National Committee for Quality Assurance (NCQA) recently awarded Simply Healthcare Plans, Inc. with an Accredited status for Medicare Advantage HMO. The NCQA



Health Plan Accreditation process assesses a health plan's structure, processes, clinical quality and patient satisfaction. NCQA Health Plan Accreditation surveys include rigorous onsite and offsite evaluations of more than 60 standards and selected HEDIS® measures.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

SHPCRNL-0004-19



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.

Reimbursement Policies

Medicaid

Policy Reminder

Modifier 63: Procedure Performed on Infants Less Than 4 kg

(Policy 06-015, effective 11/16/2018)

Simply Healthcare Plans, Inc. (Simply) allows reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 at 100 percent of the applicable fee schedule or contracted/negotiated rate. Please note, the neonate weight should be documented clearly in the report for the service.

Assistant surgeon and/or multiple procedure rules and fee reductions apply when:

- An assistant surgeon is used.
- Multiple procedures are performed on neonates or infants less than 4 kg in the same operative session.

Key Definition

Modifier 63: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number.

In applicable circumstances, Simply does not allow reimbursement for Modifier 63. To view these circumstances, please refer to the Modifier 63: Procedure Performed on Infants less than 4 kg reimbursement policy at <https://provider.simplyhealthcareplans.com/florida-provider>.

SFL-NL-0032-19

Medicaid and Medicare Advantage

Policy Update

Multiple Delivery Services

(Policy 06-044, effective 06/30/2019)

Effective June 30, 2019, Simply Healthcare Plans, Inc. (Simply) will not allow separate reimbursement for multiple deliveries performed using the same delivery method. In a combined-delivery method, Simply requires Modifier 22 to be billed, and multiple procedure guidelines will not apply.



To view the Multiple Delivery Services reimbursement policy, please visit <https://provider.simplyhealthcareplans.com/florida-provider>.

SFL-NL-0026-19

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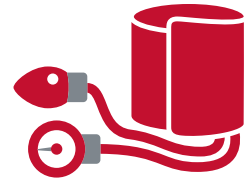


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Reimbursement Policies

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