Provider Newsletter

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

November 2020

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Want to receive the Provider Newsletter via email?

Click **here** to provide/update your email address.

COVID-19 information from Simply Healthcare Plans, Inc.

Simply Healthcare Plans, Inc. is closely monitoring COVID-19 developments and how the novel coronavirus will impact our customers and provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) to help us determine what action is necessary on our part.

For additional information, reference the *COVID-19 Updates* page on our **website**.

SFLPEC-1898-20/SFLCARE-0208-20

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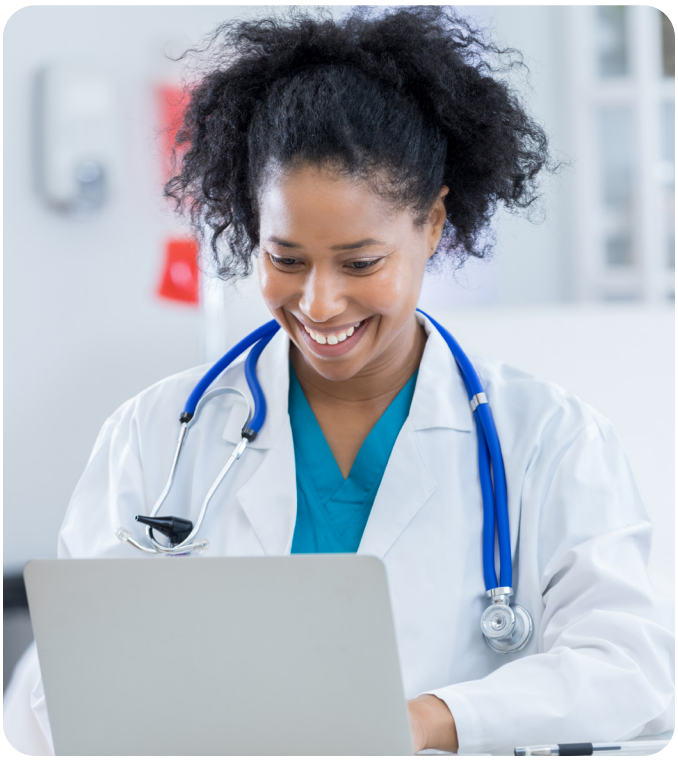

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SFL-NL-0211-20

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By eliminating paper checks, electronic funds transfer (EFT) is a digital payment solution that deposits payments directly into your account. It is safe, secure and will deliver payments to you faster. Electronic remittance advice (ERA) is completely searchable and downloadable from the Availity Provider Portal or the *EDI 835* remittance, which meets all *HIPAA* mandates — eliminating the need for paper remittances.

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** Availity, LLC is an independent company providing administrative support services on behalf of Simply Healthcare Plans, Inc.*

SFL-NL-0217-20

Transition to AIM Specialty Health *Rehabilitative Services Clinical Appropriateness Guidelines*

Effective December 8, 2020, Simply Healthcare Plans, Inc. will transition the *Clinical Criteria* for medical necessity review of certain outpatient rehabilitative services from our clinical guidelines for physical therapy CG-REHAB-04, occupational therapy CG-REHAB-05 and speech language pathology CG-REHAB-06 to AIM Specialty Health®* *Rehabilitative Service Clinical Appropriateness Guidelines*. These reviews will continue to be completed by HN1 and the FL utilization management team.

Access and download a copy of the current and upcoming guidelines **here**.*

** AIM Specialty Health is an independent company providing some utilization review services on behalf of Simply Healthcare Plans, Inc.*

SFL-NL-0180-20

Provider transparency update

A key goal of the provider transparency initiatives of Simply Healthcare Plans, Inc. (Simply) is to improve quality while managing health care costs.

One of the ways this is accomplished is through our value-based programs (for example, the Provider Quality Incentive Program, the Provider Quality Incentive Program Essentials, Risk and Shared Savings, etc.), known as the Programs.

Value-Based Program Providers (also known as Payment Innovation Providers) in our various value-based programs receive quality, utilization and/or cost data, reports and information about other health care providers (Referral Providers). The Value-Based Program Providers can use that information in selecting Referral Providers for their patients covered under the Programs. If a Referral Provider is higher quality and/or lower cost, this component of the Programs should result in the provider getting more referrals from Value-Based Program Providers. If Referral Providers are lower quality and/or higher cost, the converse should be true.

Providing this type of data, including comparative cost information, to Value-Based Program Providers helps them make more informed decisions about managing health care costs, and maintaining and improving quality of care. It also helps them succeed under the terms of the Programs.

Simply will share data on which we relied in making these quality/cost/utilization evaluations upon request, and will discuss it with Referral Providers, including any opportunities for improvement. If you have questions or need support, please refer to your local market representative or care consultant.

SFL-NL-0210-20

Inhaled nitric oxide reviews for diagnosis-related group admissions

This is a notification regarding inhaled nitric oxide.

The purpose of this notification is to inform participating hospitals that the use of inhaled nitric oxide (iNO) during an inpatient stay will be reviewed for medical necessity using our *Clinical Utilization Management (UM) Guideline* for Inhaled Nitric Oxide, CG-MED-69. iNO is a covered service for eligible members when the use of iNO meets medical necessity criteria. To view the *Clinical UM Guideline* for INO, visit **https://provider.simplyhealthcareplans.com**.

This also requires that the facility notify us of the use of iNO during the course of an inpatient review, and it must be reviewed and approved at some point prior to discharge to avoid exclusion of charges for iNO from the claim payment. If we are not alerted to the use of iNO and, therefore, medical necessity cannot be determined, and charges for iNO are included in the claim submission, the charges for iNO will not be considered in calculation of reimbursement for the stay.

When iNO is used, providers are required to submit an itemized list of charges with the claim for the inpatient stay.

Impact on the diagnosis-related group (DRG) payment

The charges for iNO that are determined to be not medically necessary will not be considered and could impact the DRG outlier payment, as the stay may not reach outlier status as soon as it would with inclusion of these charges. If the case reaches the outlier threshold, we will adjudicate the claim consistent with the financial terms of the contract for outliers, without inclusion of charges for iNO that are not medically necessary or the use of which was not disclosed.

Providers should direct questions regarding this guideline or in relation to the Utilization Management review process to the health plan numbers listed at **1-844-405-4296**.

Providers should fax new prior authorization requests for physical health inpatient services to **1-866-495-1986**.

Fax submissions of clinical documentation as requested by the Inpatient Utilization Management Department supporting medical necessity reviews for inpatient concurrent reviews to **1-866-495-1986**.

SFL-NL-0208-20

Important reminder — coding requirements for reimbursement for early elective deliveries

Simply Healthcare Plans, Inc. (Simply) appreciates the recent improvements seen in early elective delivery (EED) rates across the country. These improvements have been brought about through the collaborative efforts of state Medicaid agencies, the March of Dimes, CMS, the Joint Commission, the American College of Obstetricians and Gynecologists (ACOG), and many others. The implementation of hospital hard stop policies describing the review of clinical indications and scheduling approval for EED has also increased awareness of the harm that can be caused by non-medically necessary EED and encouraged discussion on the topic between patients, their care providers and hospitals. Voluntary efforts combined with payment reform have been found to further decrease EED rates while increasing gestational age and birth weight for the covered population.[1]

EED is defined as a delivery by induction of labor without medical necessity followed by vaginal or caesarean section delivery or a delivery by caesarean section before 39 weeks gestation without medical necessity. Vaginal or caesarean delivery following non-induced labor is not considered an early elective delivery regardless of gestational weeks.

What does this mean for providers?

To improve birth outcomes for our members and further reduce EED, Simply requires a Z3A code indicating gestational age, the appropriate code to indicate the outcome of delivery and supporting medical necessity diagnosis codes on all professional delivery claims for all EED. Simply will apply Milliman Care Guidelines, which defines medically necessary criteria for EED.

All professional delivery claims (59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622) with dates of service January 1, 2018, or after, will require a Z3A code indicating gestational age at the time of delivery. If the code is not present on the claim, the claim will deny with the explanation code e02: **Delivery diagnoses incomplete without report of pregnancy weeks of gestation.** You may resubmit the claim with the appropriate Z3A code.

- Professional delivery claims with dates of service January 1, 2018, or after, with gestational age dates of 37 and 38 weeks will require a supporting medically necessary diagnosis code for the early delivery.
- If a professional delivery claim is submitted without evidence of medical necessity for the early delivery, the claim will deny with code k34: **Delivery is not medically indicated.** You may resubmit the claim with the appropriate supporting diagnosis code or appeal with medical records.

1 Dahlen, Heather M., J. Mac Mccullough, Angela R. Fertig, Bryan E. Dowd, and William J. Riley. *Texas Medicaid Payment Reform: Fewer Early Elective Deliveries and Increased Gestational Age And Birthweight.* Health Affairs 36.3 (2017): 460-67. Print.

SFL-NL-0213-20

COVID-19 information from Simply Healthcare Plans, Inc.

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

SFLPEC-1898-20/SFLCARE-0208-20

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SFL-NL-0211-20

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SFL-NL-0217-20

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SFL-NL-0208-20

Medicare Advantage

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SFL-NL-0217-20

FDA approvals and expedited pathways used — new molecular entities

The FDA approves new drugs/biologics using various pathways of approval. Recent studies on the effectiveness of drugs/biologics going through these different FDA pathways illustrates the importance of clinicians being aware of the clinical data behind a drug or biologic approval in making informed decisions.

Here is a list of the approval pathways the FDA uses for drugs/biologics:	
Standard Review:	The Standard Review process follows well-established paths to make sure drugs/biologics are safe and effective when they reach the public. From concept to approval and beyond, FDA performs these steps: reviews research data and information about drugs and biologics before they become available to the public, watches for problems once drugs and biologics are available to the public, monitors drug/biologic information and advertising, and protects drug/biologic quality. To learn more about the Standard Review process, go **here**.
Fast Track:	Fast Track is a process designed to facilitate the development and expedite the review of drugs/biologics to treat serious conditions and fill an unmet medical need. To learn more about the Fast Track process, go **here**.
Priority Review:	A Priority Review designation means FDA's goal is to take action on an application within six months. To learn more about the Priority Review process, go **here**.
Breakthrough Therapy:	A process designed to expedite the development and review of drugs/biologics that may demonstrate substantial improvement over available therapy. To learn more about the Breakthrough Therapy process, click **here**.
Orphan Review	Orphan Review is the evaluation and development of drugs/biologics that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. To learn more about the Orphan Review process, click **here**.
Accelerated Approval:	These regulations allowed drugs/biologics for serious conditions that filled an unmet medical need to be approved based on a surrogate endpoint. To learn more about the Accelerated Approval process, click **here**.

New molecular entities approvals — January to August 2020

Certain drugs/biologics are classified as new molecular entities (NMEs) for purposes of FDA review. Many of these products contain active ingredients that have not been approved by FDA previously, either as a single ingredient drug or as part of a combination product; these products frequently provide important new therapies for patients.

Simply reviews the FDA-approved NMEs on a regular basis. To facilitate the decision-making process, we are providing a list of NMEs approved from January to August 2020, along with the FDA approval pathway utilized.

Read more online.

SHPCRNL-0067-20

Policy Update
(Medicaid & Children's Health Insurance Program — Florida Healthy Kids)

Nurse Practitioner and Physician Assistant Services, Professional

(Policy 20-002, Effective 04/24/20)

This update is to inform you that there is now a separate and specific professional reimbursement policy to reference for Nurse Practitioner and Physician Assistant Services.

Simply Healthcare Plans, Inc. continues to allow reimbursement for services provided by nurse practitioner (NP) and physician assistant (PA) providers. Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- Service is considered a physician's service
- Service is within the scope of practice
- A payment reduction of 20% reimbursement

Services furnished by the NP or PA should be submitted with their own NPI.

For additional information, review the Nurse Practitioner and Physician Assistant Services professional reimbursement policy at **https://provider.simplyhealthcareplans.com/florida-provider**.

SFL-NL-0203-20

Policy Update (Medicaid Advantage)

Emergency Department: Leveling of Evaluation and Management Services

Effective January 15, 2021, Simply Healthcare Plans, Inc. classifies with an Evaluation and Management (E&M) code level the intensity/complexity of emergency department (ED) interventions a facility uses to furnish all services indicated on the claim. E&M services will be reimbursed based on this classification. Facilities must use appropriate HIPAA compliant codes for all services rendered during the ED encounter. If the E&M code level submitted is higher than the E&M code level supported on the claim, we reserve the right to perform one of the following:

- Deny the claim and request resubmission at the appropriate level or request the provider submit documentation supporting the level billed.
- Adjust reimbursement to reflect the lower ED E&M classification.
- Recover and/or recoup monies previously paid on the claim in excess of the E&M code level supported.

Providers who believe their medical record documentation supports reimbursement for the originally submitted level for the E&M service will be able to follow the dispute resolution process in accordance with the terms of their contract. Claims disputes require a statement providing the reason the intensity/complexity would require a different level of reimbursement, and the medical records which should clearly document the facility interventions performed and referenced in that statement.

For additional information, review the Emergency Department: Leveling of Evaluation and Management Services reimbursement policy at **https://provider.simplyhealthcareplans.com/florida-provider**.

SFLCARE-0317-20

COVID-19 information from Clear Health Alliance

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SFLPEC-1898-20

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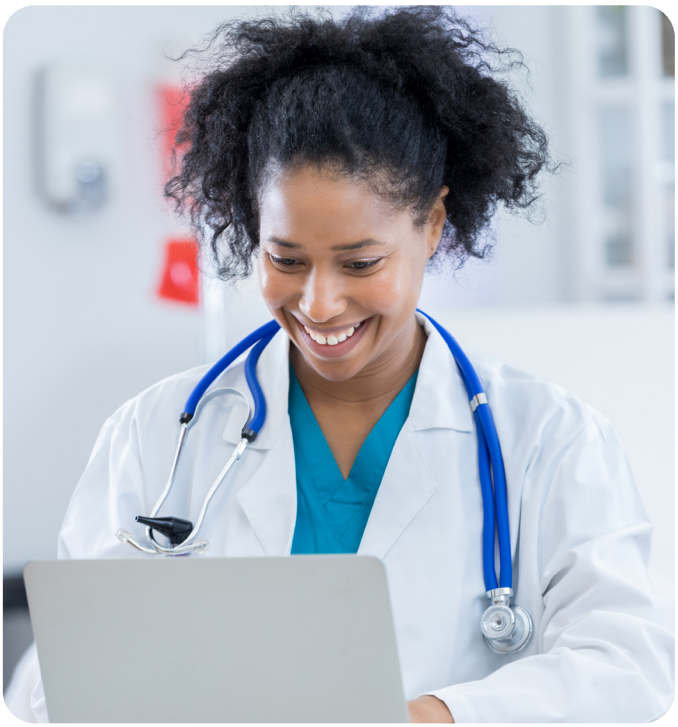

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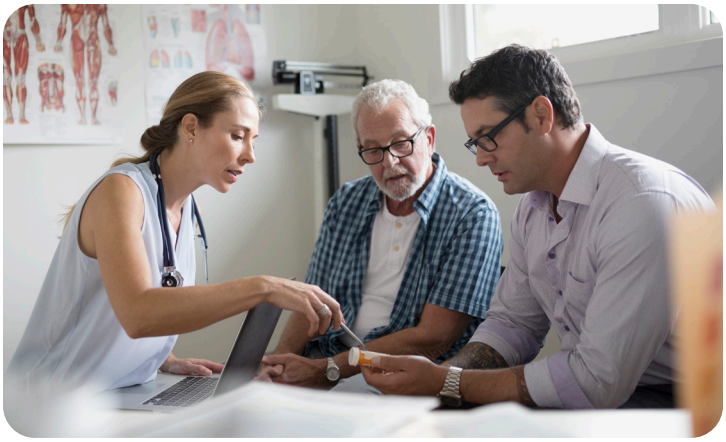

Coding spotlight: tips and best practices for compliance

Need for coding compliance

Coding compliance refers to the process of ensuring that the coding of diagnosis, procedures and data complies with all coding rules, laws and guidelines.

All provider offices and health care facilities should have a compliance plan. Internal controls in the reimbursement, coding, and payment areas of claims and billing operations are often the source of fraud and abuse, and have been the focus of government regulations.

Compliance plan benefits:

- More accurate payment of claims
- Fewer billing mistakes
- Improved documentation and more accurate coding
- Less chance of violating state and federal requirements including self-referral and anti-kickback statutes.

Compliance programs can show the provider practice is making an effort to submit claims appropriately and send a signal to employees that compliance is a priority.

Read more online.

SCFL-NL-0008-20

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