



MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM

General Provider Transmittal No. 85

February 12, 2018

TO: Clinics
Dental Providers
Federally Qualified Health Centers
Home Health Agencies
Hospitals
Local Health Departments
Managed Care Organizations
Nurse Midwives
Nurse Practitioners
Physicians
Physician Assistants

FROM: *Susan J. Tucker*
Susan J. Tucker, Executive Director
Office of Health Services

RE: Medicaid Program Updates for Winter 2018

NOTE: Please ensure that the appropriate staff members in your organization are informed of the content of this transmittal.

ePREP

Maryland Medicaid launched Phase I of its new Electronic Provider Revalidation and Enrollment Portal (ePREP) in late Fall 2017. When fully implemented, ePREP will be the one-stop shop for enrollment, re-enrollment, re-validation, provider updates, and demographic changes. There are two phases of ePREP implementation. Phase I includes most solo practitioners, rendering-only providers, and group practices. Phase II go-live, scheduled for Spring 2018, includes hospitals, clinics, other medical facilities, and long term services and supports waivers providers.

Maryland Medicaid also launched a Call Center to coincide with ePREP's go-live. Automated Health Systems (AHS) will operate the Call Center and ePREP through its subcontractor, Digital Harbor. You can reach the Call Center at 1.844.4MD.PROV (1.844.463.7768).

Please visit ePREP.health.maryland.gov to access Maryland Medicaid's ePREP. For more information about Maryland Medicaid's phased approach, as well as FAQs and instructions for credentialing, please visit health.maryland.gov/ePREP.

Recipient Status Changes

To prevent Medicaid participants from losing coverage due to life changes, please encourage your patients to update their Maryland Health Connection accounts any time they experience significant life changes—including pregnancy, change of address, or change in job status. Medicaid participants can make updates to their accounts using any of the following options:

- Go to MarylandHealthConnection.gov; use the “Change My Information” button on your homepage
- Get in-person help from a connector entity, local health department, or local department of social services
- Download the free Enroll MHC app
- Call Maryland Health Connection at 1-855-642-8572 (TTY: 1-855-642-8573)

Prior Authorization Changes under the Maryland Contraceptive Equity Act Effective January 1, 2018

Six-month Supply of Prescription Contraceptives

Medicaid fee-for-service and HealthChoice MCOs must provide coverage for a single dispensing of a six-month supply of prescription contraceptives. This requirement does not apply to the first two-month supply of prescription contraceptive dispensed under the initial prescription or any subsequent prescription for a contraceptive that is different than the last contraceptive dispensed.

Preauthorization Limitations for Contraceptives

Medicaid fee-for-service and HealthChoice MCOs are prohibited from applying a prior authorization requirement for an intrauterine device (IUD) or implantable rod that is FDA-approved and obtained under a written prescription, unless the FDA has issued a black box warning (a warning on the prescription drug or device’s label designed to call attention to serious or life-threatening risks).

If you have any questions regarding this policy change, please contact:

- MCOs: Pam Williams, (410)767-3532, pam.williams@maryland.gov
- Hospitals: Patrick Wheeler, (410)767-1724, patrick.wheeler@maryland.gov
- Clinics: Earl Tucker, (410)767-4078, earl.tucker@maryland.gov
- Nurse Midwives, Nurse Practitioners, and Obstetricians: Christa Smith, (410) 767-1462, christa.smith@maryland.gov

Remote Patient Monitoring

Effective January 1, 2018, the Maryland Department of Health (MDH) will reimburse for remote patient monitoring (RPM) services for certain chronic conditions.

RPM is a service which uses digital technologies to collect medical and other forms of health data from individuals and electronically transmits that information securely to health care providers for assessment, recommendations, and interventions. Providers should order RPM when it is medically necessary to improve chronic disease control and it is expected to reduce potentially preventable hospital utilization.

Preauthorization Requirements

Medicaid participants who have had with one of the following conditions may qualify for RPM:

- Chronic Obstructive Pulmonary Disease (COPD);
- Congestive Heart Failure; or
- Diabetes (Type 1 or Type 2).

To receive RPM, the participants must be enrolled in Medicaid, consent to RPM, have the internet connections and capability to use the monitoring tools in their homes, and have one of the following scenarios within a 12-month period:

- Two hospital admissions with the same qualifying medical condition (COPD, congestive heart failure, or diabetes) as the primary diagnosis;
- Two emergency department visits with the same qualifying medical condition as the primary diagnosis; or
- One hospital admission and one emergency department visit with the same qualifying medical condition as the primary diagnosis.

Referrals for RPM may cover an episode of up to 60 days of monitoring. Eligible participants may only receive two episodes of RPM during a rolling 12-month period.

Physicians or home health agencies can provide RPM; however, the authorization limits apply across programs. Therefore, a participant cannot receive more than a total of two episodes of RPM, regardless of who is rendering the service, during a rolling 12-month period.

The preauthorization form is available at <https://mmcp.health.maryland.gov/Pages/RPM.aspx>.

RPM Reimbursement

Revenue code **0581** (for home health agencies) and HCPCS code **S9110** (for all other professionals) will be reimbursable for RPM. The RPM rate is an all-inclusive rate of \$125 per 30 days of monitoring, which covers:

- Equipment installation;
- Participant education for using the equipment; and
- Daily monitoring of the information transmitted for abnormal data measurements.

The rate does not include and Medicaid will not pay for:

- RPM equipment;
- Upgrades to RPM equipment; or
- Internet service for participants.

The criteria outlined are for fee-for-service participants receiving RPM. Managed care organizations may preauthorize and reimburse differently for HealthChoice participants. Please contact HealthChoice MCOs for more information about their RPM requirements.

Home health agency preauthorization for RPM should be faxed to Tia Lyles at 410-333-5085. For other professionals (clinics, FQHCs, hospitals, physicians, nurse practitioners, or physician assistants), preauthorization for RPM should be faxed to Monasha Holloway at 410-333-5050.

If there are questions regarding the preauthorization process for RPM, please contact:

- Home Health: Tia Lyles, 410-767-1448, tia.lyles@maryland.gov; or
- Other Professionals: Monasha Holloway, 410-767-1737, monasha.holloway@maryland.gov.

Hospital Presumptive Eligibility (HPE) EVS Change & Reminder

Electronic Verification System (EVS) Message Change as of July 1, 2017

Currently, the EVS message for HPE enrollees states: "Recipient eligible. Full fee-for-service benefits: Hospital Presumptive Eligibility." Because Maryland Medicaid is adding a new Presumptive Eligibility program which has the same coverage span rules as HPE, Maryland Medicaid has changed the EVS message to identify an individual as a Presumptive Eligibility enrollee generally. As of July 1, 2017, the message for HPE and other Presumptive Eligibility enrollees will say: "Recipient eligible. Full fee-for-service benefits: Presumptive Eligibility."

2018 Physician Updates

Effective January 1, 2018, the Maryland Medical Assistance Program (Maryland Medicaid) updated the Professional Services Fee Schedule. To view the 2018 Professional Services Fee Schedule and Manual, please go to <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>. The Professional Services Fee Schedule includes new CPT codes for 2018, as well as a separate section for injectable/provider administered drugs (J codes).

Maryland Medicaid Electronic Health Record (EHR) Incentive Program

The Maryland EHR Incentive Program team is assisting providers prior to attestation by reviewing patient volume and Meaningful Use documentation. Please submit questions or requests for Program Year 2017 documentation review to our team via email at mdh.marylandehr@maryland.gov.

Maryland is extending its Program Year 2017 deadline for the Medicaid EHR Incentive Program to April 13, 2018 for both Eligible Professionals and Eligible Hospitals.

eMIPP is currently locked while Maryland updates the system to align with federal requirements. We expect to unlock eMIPP mid-February of 2018.

Please note that Program Year 2016 was the last year to begin participation in the Medicaid EHR Incentive Program. Only providers that have received payment for a prior program year will be able to participate in Program Year(s) 2017-2021.

Correction to Spinraza NDC

Effective January 1, 2018, preauthorized injections of Spinraza will be reimbursed using HCPCS code J2326 with the NDC 64406-0058-01. The Maryland Department of Health has identified an error in the National Drug Code (NDC) that providers were previously instructed to use when billing for all preauthorized administrations of Spinraza. The error was made in PT 41-17 Preauthorization Guidelines and Coverage Criteria for Spinraza (Nusinersen). Until January 1, 2018, continue to bill with HCPCS Code J3490 with the modifier KX and the correct NDC 64406-0058-01.

Billing of Unspecified Codes

The Department requests all professionals who bill an unlisted (e.g., 39599 – unlisted procedure, diaphragm, 66999 – unlisted procedure, anterior segment of eye) CPT or HCPCS code on a CMS-1500, include comparable code(s), if any, in the medical documentation that is provided for review with the claim. This will allow the physician reviewer to review and price the claim more quickly.

PALB2 Test

Effective March 1, 2018, the Maryland Department of Health (MDH) will reimburse for the PALB2 (partner and localizer of BRCA2) laboratory test. The PALB2 is a tumor suppressor gene which encodes for the PALB2 protein. The PALB2 protein assists BRCA2 in DNA repair and tumor suppression. Laboratories that will be billing for this test must use CPT code 81406 and attach documentation verifying the test was completed. If you have questions regarding the reimbursement for the PALB2 laboratory test, please contact Tenesha Lynch at tenesha.lynch@maryland.gov.

Updates to Managed Care COMAR Regulations

In April 2016, the Centers for Medicare & Medicaid Services (CMS) issued final regulations that revise existing Medicaid managed care rules, including several new requirements for contract periods beginning on or after July 1, 2017. The Department's contractual relationship with its managed care organizations (MCOs) operates on a calendar year basis. The following is a summary of the updates to COMAR which may impact providers beginning January 1, 2018.

Service Authorizations, Appeals, and Grievances

- An MCO's determination window for preauthorization decisions will be as follows:
 - For standard authorization decisions, within 14 days;
 - For expedited authorization decisions, within 72 hours; and
 - For covered outpatient drug decisions, within 24 hours, by phone (COMAR 10.09.71.04A).
- When entering into a contract, MCOs must provide information about the grievance and appeal system to all providers and subcontractors (COMAR 10.09.65.17A (3) (n)).
- Enrollees and their representatives may file appeals and grievances orally or in writing (COMAR 10.09.71.02A).
 - The time frame in which an enrollee can request an appeal has been reduced from within 90 days to within 60 days from the date of the MCO's action (COMAR 10.09.71.05A).
 - Enrollees can file a grievance at any time.
- Providers may serve as representatives for enrollees in the appeal and grievance process if the enrollee provides **written permission**.
- MCOs may only have one level of enrollee appeal, and enrollees must first appeal to the MCO before requesting a State fair hearing.
- Decision makers in an MCO's appeal and grievance process may not be subordinates of people involved in previous levels of decision making and must consider all documents,

comments, records, and other information submitted by the enrollee or their representative (COMAR 10.09.71.02C).

- The window for requesting a State fair hearing has been extended to within 120 days of the notice of the appeal resolution (COMAR 10.01.04.04D).
- MCOs must authorize or provide disputed services within 72 hours of their decision or the State fair hearing decision to overturn the initial denial (COMAR 10.01.04.08D (4)).

Care Coordination

- MCOs must have mechanisms in place to allow enrollees with special health care needs to access a specialist directly (COMAR 10.09.65.04C (10)).
- MCOs may place limits on services based on criteria applied under the State plan (COMAR 10.09.67.01D).
- MCOs must ensure that compensation related to utilization management activities is not structured to provide incentives which may harm the enrollee (COMAR 10.09.67.04I).
- MCOs may not apply copayment or coinsurance to contraceptive drugs or devices and shall provide coverage for a single dispensing of a supply of prescription contraceptives for a 6-month period (COMAR 10.09.67.19C—D).

Program Integrity

- MCOs must have provisions in its subcontractor agreements for:
 - Subcontractor compliance with all state and federal requirements regarding audit, inspection, and evaluation;
 - Provisions to revoke delegation of activities or obligations from subcontractors if they do not meet the terms of the agreement; and
 - The rights of the federal and state to audit the subcontractor for 10 years from the final day of the contract period (COMAR 10.09.65.17A).
- MCOs must develop a mechanism for network providers to report and return overpayments to the MCO (COMAR 10.09.68.01K).

Information Requirements

- MCOs must make a good faith effort to keep their provider directories accurate by updating information monthly. The directory should be made available on an MCO's website in a machine-readable file and format (COMAR 10.09.66.02 G—H).