Provider NEWSLETTER

maryland physicians care
Medicaid with a Heart

EDITION 4, 2023

Table of Contents

HELP YOUR PATIENTS KEEP THEIR MEDICAID COVERAGE WITH MPC!

Maryland Medicaid requires members to renew their coverage.

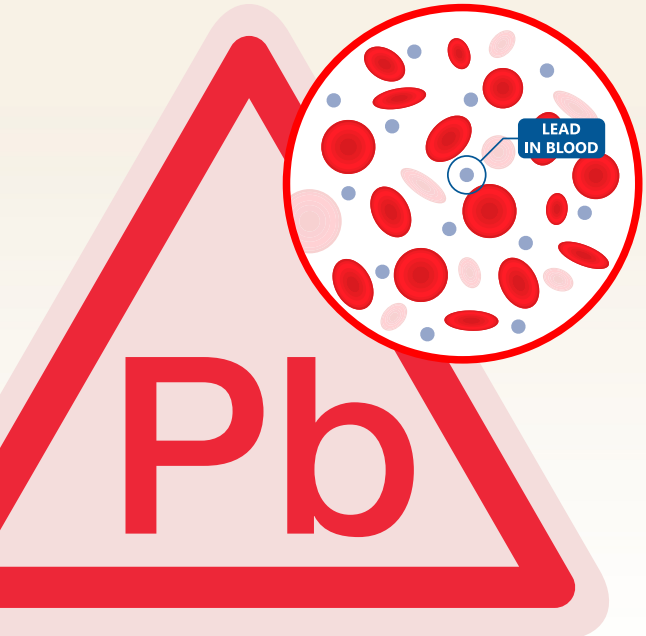
Medicaid renewals **will not** be automatic this year. Your patients **must** renew their coverage with Maryland Health Connection this year to keep their health insurance benefits. Patients can renew their insurance by:

1. **GOING ONLINE** to Maryland Health Connection at https://marylandhealthconnection.gov/checkin
2. **CALLING** Maryland Health Connection's Customer Service at 855-642-8572
3. **VISITING** MPC's website at mpcMedicaid.com/renew-membership

REMIND your patients to take these important steps to keep their MPC coverage.

Primary Care Providers can access a list of MPC patients that will be coming up for Medicaid renewal over the next 90 days on the MPC Provider Web Portal. Contact your Provider Rep if you need assistance accessing this list. **For more information to assist your patients, please visit the MDH website.**

Importance of Lead Screenings



Protecting children from exposure to lead is important to lifelong good health. No safe blood lead level in children has been identified. Even low levels of lead in blood have been shown to negatively affect a child's intelligence, ability to pay attention, and academic achievement. Healthcare providers play a key role in preventing lead poisoning by identifying children at a higher risk, testing their blood lead levels, and connecting families to any needed follow-up services.

For resources and guidance documents to support effective childhood lead poisoning prevention programs, visit this website: https://www.cdc.gov/nceh/lead/resources/guidelines.html.

Please ensure all your patients have had lead testing according to the Maryland Healthy Kids Preventive Health Schedule.

CRISP: A Vital Tool for Improving Continuity of Care & Member Satisfaction

The Chesapeake Regional Information System for our Patients (CRISP) is a regional health information exchange (HIE) in Maryland and the District of Columbia. CRISP clinical data is available through the CRISP portal at no cost to clinical staff. Clinical data from participants can be reviewed at the point of care.

Features include:

- Near real-time clinical information.
- Up-to-date patient demographic data, allowing for easier patient outreach.
- Health records and images, including histories and physicals, discharge summaries, lab data, and radiology data.
- Care team information to help ensure coordination with all entities that have a relationship with a patient — this could include primary care providers, managed care organizations, care management programs in which the patient is enrolled, and alerts that indicate if a care plan is available on the CRISP Health Records portal.
- Patient Care Snapshot that provides information about interactions with the health care system, including emergency, inpatient, and outpatient environments — this can help identify gaps in care or alert of overuse of emergency services.
- Encounter Notification Service (ENS) alerts providers when patients present in the emergency room or are hospitalized, allowing for coordination of care and prompt follow-up after discharge.

Using CRISP improves continuity of care by providing you with information from other care team participants. It can also improve member satisfaction ratings. The annual Member Satisfaction Survey includes a question related to how informed your provider seemed about healthcare received from other providers.

MPC strongly recommends you use CRISP in your day-to-day practice. For more information on CRISP, visit https://crisphealth.org/ or call 1-833-580-4646.

Go to https://crisphealth.org/resources/training-materials/ for resources and training materials.

Availability of UM Criteria

To make UM decisions, MPC uses nationally recognized, evidence-based criteria that are applied based on the needs of individual members and characteristics of the local delivery system. Medical review criteria used include:

- Criteria required by applicable state or federal regulatory agencies
- Applicable InterQual Criteria as the primary decision support for most medical diagnoses and conditions
- MPC Clinical Policy Guidelines

The UM decision-making criteria are available upon receiving a denial. If you would like a copy of the criteria, please contact MPC's Utilization Department at 1-800-953-8854 and follow the prompts to the Customer Service Department.

MPC Correct Coding Corner:

Noninvasive Pulse Oximetry

Pulse oximetry is a simple, noninvasive method of monitoring the oxygen saturation of arterial blood. Performing this service consists of placing a probe on the patient's finger or ear lobe to detect the percentage of Hb saturated with oxygen.

Effective January 1, 2024, MPC will deny pulse oximetry (CPT Codes 94760 and 94761) when billed on a professional claim and bundled with an evaluation and management (E/M) service, with or without a modifier, on the same date by the same provider. Pulse oximetry represents a fundamental component of the assessment services provided to a patient during a visit and, therefore, is not separately reimbursable.

Emergency Room Sudden and Serious List - Updated

MPC's Emergency Room Sudden and Serious List has been updated and shared on our website under the Provider Resources/Billing and Claims Section. This list includes ICD-10 codes designating an emergency room visit that requires immediate medical attention, which will automatically adjudicate hospital claims. Newly added codes go into effect for emergency room claims with dates of service on or after December 1, 2023.

Credentialing Requirement

REMINDER: If credentialing is required and not initiated for practitioners in contracted groups, MPC considers the practitioner as an out-of-network provider when adjudicating claims. Please forward your credentialing material prior to servicing members and submitting claims.

3D Mammograms and Member Financial Liability

Following the recommendation by the U.S. Preventive Services Task Force, MPC covers 2-D mammograms for its members and 3D diagnostic mammograms only with prior authorization.

MPC policy reimburses claims submitted for a 2D screening mammogram using CPT 77067. For providers billing 3D screening mammograms, providers can submit claims with the 2D CPT code and the add-on code. The 3D screening add-on code 77063 will be denied as a non-covered service, and only the CPT 77067 will be reimbursed. Providers with members who accept financial responsibility for the 3D add-on code, CPT 77063, before the rendered service may bill members for the 3D portion of the claim. Please remember this financial responsibility form is specific to the service and is not the general financial responsibility form. Providers without a signed financial responsibility form for the 3D add-on code may not balance bill Medicaid members.

MPC policy will reimburse a 3D diagnostic mammogram only when an approved prior authorization is obtained for this service.

Inpatient Hospital Billing

Outpatient Services Treated as Inpatient Services:

As stated in Medicare Claims Processing Manual, Chapter 3, Section 40.3, preadmission services within 72 hours of inpatient admission always have to be bundled into 11x TOB for the same provider.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf

Preadmission Services

- When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services.
- Diagnostic and non-diagnostic services by the admitting facility within three days prior to and including the date of the admission are deemed to be inpatient services and included in the inpatient payment.

Billing Procedures to Avoid Duplicate Payments

The hospital must install adequate billing procedures to avoid submission of duplicate claims. This includes duplicate claims for the same service and outpatient bills for nonphysician services considered included in the related inpatient admission in the facility. Ambulance and maintenance renal dialysis services are excluded.

Admission Date and Statement Covers Period Billing

The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day:

- Admission Date = date patient was admitted as an inpatient to facility.

  On the inpatient claim, this is the day on which the patient is formally admitted as an inpatient with a signed and dated physician order. It is the first inpatient day the patient is receiving services.

- Statement Covers Period = span of service dates; "From" date is earliest date of service on bill.

  On the inpatient claim, a valid "from" date could be up to and including 3 days (or 1 day) prior to the actual inpatient admission based on the preadmission bundling rule.

https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/se1117.pdf

Maryland Healthy Kids Program /EPSDT

The Maryland Department of Health (MDH) requires that Primary Care Providers (PCPs) who treat members under the age of 21 become EPSDT-Certified. MPC cannot assign members to a PCP's panel without a parent's consent if the provider is not EPSDT-Certified. To find out more about the application and certification process, visit https://health.maryland.gov/mmcp/epsdt/pages/home.aspx.

At this site, you can also find resources such as:

- Childhood immunization schedule
- Preventive health schedule
- Recommended forms for use during wellness visits
- Billing guidelines
- Additional valuable resources

Family Planning Benefits

Did you know MPC covers comprehensive family planning services such as:

- Office visits for family planning services
- Laboratory tests, including pap smears
- All FDA-approved contraceptive devices, methods, and supplies
- Immediate Postpartum Insertion of IUDs
- Oral Contraceptives (must allow a 12-month supply to be dispensed for refills)
- Emergency contraceptives and condoms without a prescription
- Voluntary sterilization procedures (Sterilization procedures are not self-referred; members must be 21 years of age and must use an in-network provider or have authorization for out-of-network care.)

2023 MEMBER SATISFACTION RESULTS ARE AVAILABLE!

The Consumer Assessment of Healthcare Provider and Systems (CAHPS®) Survey is an anonymous survey that asks health plan members about their experience with their healthcare, including their experience with the care and service provided by their providers. Physicians and office staff are critical drivers of performance on the survey.

The 2023 CAHPS® Survey Results for both Children and Adults are available on the website at https://www.marylandphysicianscare.com/quality-improvement/. Provider-specific results are not available as the survey is anonymous. However, if you would like additional details or have questions about the survey or results, please contact Customer Service at 1-800-953-8854 and ask for the Quality Management Department.

Pharmacy Benefit Coverage

Maryland Physicians Care is committed to delivering a cost-effective and inclusive medication formulary for our membership. We utilize a Preferred Drug List (PDL) that provides an overview of the medications we cover and details the utilization management requirements we have implemented for our formulary. The procedures for prior authorization, step therapy, quantity limits, and exclusions are highlighted in the PDL. The most up-to-date version of our PDL is listed here: For Providers -> Approved Drug Benefits. The section also includes monthly formulary change updates and formulary recommendations for asthma controller medications and HIV medication management. For any questions regarding pharmacy prior authorizations or requests for a printed copy of our PDL, please call 1-800-953-8854.

Visit RadMD for Clinical Authorization Information

RadMD is a user-friendly, real-time tool offered by National Imaging Associates, Inc. (NIA)*, an Evolent brand that provides ordering and rendering providers with instant access to prior authorization requests for specialty procedures. Whether submitting exam requests or checking the status of prior authorization requests, providers will find RadMD to be an efficient, easy-to-navigate resource.

Both **ordering and rendering providers** can access a range of online tools and associated specialty information on the www.RadMD.com website. Providers have:

- Access up-to-the-hour authorization information, including:
  - Date request initiated
  - Date procedure approved
  - Authorization validity period
  - Valid billing (CPT®) codes and more
- Ability to upload clinical documentation directly to RadMD
- Access to evidence-based clinical review criteria
- Technical support is available if you have questions while you and your patients' data is secure

Plus, **ordering providers** can access several key NEW RadMD tools that allow you to:

- View requests for additional information and determination letters
- View procedure-specific checklists of required documents
- Change the rendering provider
- Withdraw authorizations
- Track authorizations in alternative ways
- View and manage authorization requests with other users using Shared Access

Information for Rendering Providers:

Rendering providers can also use RadMD to submit prior authorization requests and quickly view pending, in-review, and approved authorizations for their facility, ensuring prompt service for patients who require specialty procedures.

To get started, go to RadMD.com, click the New User button and submit an Application for a New Account. If you are an imaging facility or hospital that performs exams, an administrator must be identified, as this is the person who will grant access to Taxpayer Identification Numbers (TINs). Your RadMD login information (username and password) should not be shared. Additionally, rendering providers can view approved, pended, and in-review authorizations for their facility and submit requests for advanced imaging procedures on behalf of the ordering provider.

To get started, simply go to www.RadMD.com, click the New User button, and set up a unique username/account ID and password for each individual user in your office or facility.

For more information, provider education requests, or questions specific to NIA, please feel free to contact Charmaine Everett, Senior Manager, Provider Relations, at NIA: CEverett@Evolent.com or at 1-410-953-2615.

Managing Complex Care

Members with high-risk, complex, or catastrophic conditions, including asthma, diabetes, sickle cell disease, HIV or AIDS, and congestive heart failure, often have difficulty facilitating care on their own. An MPC care manager may be able to help.

Care managers are advocates, coordinators, organizers, and communicators. They are trained nurses and practitioners who promote quality and cost-effective outcomes by supporting you, your staff, your patients, and their caregivers.

A care manager connects the Maryland Physicians Care member with the healthcare team by providing a communication link between the member, his or her primary care physician, the member's family, and other healthcare providers, such as physical therapists and specialty physicians. Care managers help members understand the benefits of following a treatment plan and the consequences of not following the plan outlined by the physician.

Our team is here to help your team with the following:

- Noncompliant members
- New diagnoses
- Complex multiple comorbidities

Providers may make a referral by contacting our Special Needs Coordinator at:

Toll-Free: 1-800-953-8854 or 443-300-7325

Fax: 1-844-284-7698

Email: MPCSNC@mpcmedicaid.com

Discussing a Denial with MPC's Medical Director

If a request for service is denied due to lack of medical necessity, the requesting provider can request to speak with an MPC Medical Director to conduct a Peer-to-Peer (P2P). The intent of the P2P is to discuss the denial reason(s) with the ordering clinician or attending physician.

To request a P2P regarding a denial, please call 410-412-8297 and leave the following information:

- **Member name**
- **Member DOB**
- **Authorization # (if known)**
- **Caller's name and contact information**
- **Provider name** (Clinician to perform P2P)
- **Provider phone number**
- **Provider's available dates and time(s)***

*Please note that MPC attempts to accommodate the provider's availability, but if the provider's availability is more than three business days from the date of the request, the provider must file an appeal.

MPC must receive the P2P request within two business days of the initial notification of the denial. MPC has three business days to respond to P2P requests.

If the MPC Medical Director returns the P2P request and is required to leave a message, the provider has two business days to return the call, or the denial will be upheld, and the provider will need to file an appeal.

For pharmacy services or medications reviewed by ESI (Express Scripts), please contact Express Scripts for P2P requests at 1-800-753-2851. For services reviewed and denied by NIA (National Imaging Associates, Inc.), please contact NIA for P2P questions at 1-800-424-4836.

Self-Service Options Available

There are many time-saving self-service options available to providers on MPC's website and portal. These tools assist with identifying member needs and supporting your office's administrative functions, such as submitting and checking claims, authorizations, and appeals. Be sure you are registered to use the secure online web portal:

- Review Member Panel Redetermination Dates occurring within the next 90 days
- Review Gaps in Care Reports
- Easily check patient eligibility
- View, manage, and download your patient list
- View claims
- View and submit service authorizations
- Communicate with us through secure messaging
- Maintain multiple providers on one account
- Control website access for your office

Other Provider Resources Available on the MPC website:

- Provider Billing Guidance
- Appeals Submission
- Electronic Funds Transfer Guidance
- Operational Updates
- Searchable Drug Formulary
- Searchable Prior Authorization Requirements
- Downloadable Provider Manual
- Info about MPC's Diabetes Prevention Program
- Pregnancy-Related Support Services
- Maryland Health Kids Preventive Health Schedule

Affirmation statement regarding incentives:

MPC bases UM decision making only on the appropriateness/medical necessity of the care and service being provided. MPC does not reward health care providers or other individuals for issuing denials of coverage or service. There are no financial incentives for UM decision makers to encourage underutilization.

If you would like to obtain a copy of the criteria used to make decisions, you can contact MPC's Utilization Department by calling 800-953-8854 and following the prompts to the Customer Service Department.

Keep Us Informed

MPC needs to be notified if your practice is unable to accept new members. It is important that we have accurate information in our provider directory, as members use the directory to select practitioners. By providing updated information, you can assist MPC in providing the best care we can for our members. It is also important for us to know if you plan to move, change phone numbers, or change your network status. **Call 1-800-953-8854 to update or verify your contact information or status.** You can also check your information on our secure provider portal. Please let us know at least 30 days before you expect a change to your information.

VISIT OUR WEBSITE

FIND INFORMATION ON:

- Quality Improvement Program
- Population Health Management Programs
- Case Management Programs
- Health and Wellness
- Clinical Practice Guidelines
- Utilization Management, including Decision-making Criteria, Affirmative Statement, and Staff Availability
- Pharmacy and Prescription Drug Management
- Benefits and Coverage
- Member Rights and Responsibilities
- Protected Health Information Use and Disclosure
- Provider Manual
- Member Handbook
- Provider Directory
- Credentialing Rights

If you do not have internet service, you can reach us by phone (numbers listed in "Who to Call") for more information.

WHO TO CALL

PROVIDER SERVICES
Claims, status, network participation, member eligibility, etc.
1-800-953-8854

MEMBER SERVICES
Benefits, ID cards, appeals, PCP changes, etc.
1-800-953-8854

MARYLAND HEALTHY SMILES DENTAL PROGRAM
1-855-934-9812

PUBLIC MENTAL HEALTH SERVICES
1-800-888-1965

SUPERIOR VISION
1-800-428-8789

UTILIZATION MANAGEMENT
1-800-953-8854

CASE MANAGEMENT
1-800-953-8854

HEALTH EDUCATION REQUESTS
1-800-953-8854

Referrals and MPC

Please note that MPC does not require referrals for specialist care.

Fraud and Abuse

MPC needs your help to prevent fraud and abuse!

We encourage you to report anything suspicious you may have seen. You may report fraud and abuse without the fear of retaliation by calling MPC's Compliance Hotline at 1-866-781-6403 or going online at MPC Fraud and Abuse.

Enroll in ePREP

Are you enrolled in the electronic Provider Revalidation and Enrollment Portal (ePREP)? ePREP is a requirement for Maryland Medicaid providers. It is a one-stop shop for provider enrollment, re-enrollment, revalidation, information updates, and demographic changes. Please ensure you are enrolled and that your information is consistently kept up to date. Providers who do not enroll or have out-of-date information may not be paid for services to Maryland Medicaid recipients. Review these tips (.pdf) for getting started and for additional resources. Enroll or update your information at eprep.maryland.health.gov.

The Provider Web Portal

MPC offers a convenient and secure access portal that is available 24/7.

- View, submit, and adjust claims for service dates
- Easily check patient eligibility
- View, manage, and download your patient list
- View and submit service authorizations
- Communicate with us through secure messaging
- Maintain multiple providers on one account
- Control website access for your office
- View historical patient health records
- Submit assessments to provide better patient care

Here is the link; create your account today!

Login ■ Maryland Physicians Care

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