SPRING 2019

NETWORK INSIDER

Cigna-HealthSpring news you can use

FLUOROQUINOLONE ANTIMICROBIALS

Are they worth the risks?

Over the past decade, the Food & Drug Administration (FDA) has issued numerous safety warnings associated with systemic fluoroquinolone antimicrobials. As additional evidence is discovered and side effects compound, it's becoming increasingly important to ensure fluoroquinolones are only administered to patients for treatment of serious bacterial infections in which benefits outweigh risks.

TIMELINE OF WARNINGS

July 8, 2008:[1] The FDA added a boxed warning, which is the FDA's highest warning, regarding the increased risk of tendinitis and tendon rupture. This risk is further increased in patients over age 60, with kidney, heart, or lung transplants, and with use of concomitant steroid therapy.

August 15, 2013:[2] The FDA highlighted a new warning for potentially irreversible peripheral neuropathy. This severe side effect can occur at any time during treatment with fluoroquinolones, often within a few days, and may be disabling.

May 12, 2016:[3] The FDA recommended restricting use of fluoroquinolones for certain uncomplicated infections when other treatment options are available. The serious risks generally outweigh the benefits for the following bacterial infections: acute sinusitis, acute bronchitis, and uncomplicated urinary tract infections. This recommendation was updated **July 26, 2016**[4] to a boxed warning regarding the risk of the disabling and potentially permanent side effects of tendons, muscles, joints, nerves, and central nervous system.

continued on next page

IN THIS ISSUE

Cigna HealthSpring CarePlan

TEXAS Medicare Medicaid PLAN
Su Plan de Salud ★ Su Opción

TEXAS Health and Human Services

FLUOROQUINOLONE ANTIMICROBIALS *CONTINUED*

July 10, 2018:[5] The FDA strengthened the current warnings in the prescribing information that fluoroquinolones may cause significant decreases in blood sugar and certain mental health side effects. Fluoroquinolone-induced hypoglycemia can be severe, potentially leading to coma and/or death. Hypoglycemia was found to occur most frequently in the elderly and those with diabetes taking an oral hypoglycemic medication or insulin. While the mental health side effects were previously described in the drug labels, the new changes made the side effects of attention disturbances, disorientation, agitation, nervousness, memory impairment, and delirium more prominent/evident and consistent across the fluoroquinolone class.

December 20, 2018:[6] The FDA released a strong warning for increased occurrence of rare but serious events of aortic ruptures. This was an update to a previous FDA announcement on May 10, 2017, after multiple recent studies demonstrated that the risk of an aortic aneurysm rupture was twice as high in patients taking fluoroquinolones. The FDA recommends that health care professionals avoid prescribing fluoroquinolones to patients with an aortic aneurysm or at high risk for an aortic aneurysm. High-risk patients include those with peripheral atherosclerotic vascular disease, hypertension, certain genetic conditions such as Marfan syndrome and Ehlers-Danlos syndrome, and elderly patients.

The FDA strongly encourages health care providers to prescribe fluoroquinolones to patients without risk factors for medication adverse effects, and for those in whom a bacterial infection is severe enough to warrant fluoroquinolones where other antimicrobial options would not be medically appropriate. When prescribing fluoroquinolones, patients should be advised of all potential adverse effects and instructed to seek medical attention for any symptoms potentially associated with side effects. Additionally, the FDA urges health care providers, as well as patients, to report side effects involving fluoroquinolones or other medications to the FDA MedWatch program. For more information or to subscribe to FDA MedWatch alerts, please visit www.fda.gov/Safety/MedWatch.

Marketed fluoroquinolones currently include: ciprofloxacin (Cipro®, Cipro® XR, Proquin® XR), gemifloxacin (Factive®), levofloxacin (Levaquin®), moxifloxacin (Avelox®), norfloxacin (Noroxin®), and ofloxacin (Floxin®).

continued on next page

FLUOROQUINOLONE ANTIMICROBIALS *CONTINUED*

References

1. U.S. Food and Drug Administration (FDA): Information for Healthcare Professionals: Fluoroquinolone Antimicrobial Drugs Increased risk of Tendinitis and Tendon Rupture. U.S. Food and Drug Administration (FDA). Silver Spring, MD. 2008. Available from URL: http://wayback.archive-it.org/7993/20170112032310/http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm126085.htm. As accessed January 2019.
2. U.S. Food and Drug Administration (FDA): FDA Drug Safety Communication: FDA requires label changes to warn of risk for possibly permanent nerve damage from antibacterial fluoroquinolone drugs taken by mouth or by injection. U.S. Food and Drug Administration (FDA). Silver Spring, MD. 2013. Available from URL: http://wayback.archive-it.org/7993/20170112031629/http://www.fda.gov/Drugs/DrugSafety/ucm365050.htm. As accessed January 2019.
3. U.S. Food and Drug Administration (FDA): FDA Drug Safety Communication: FDA advises restricting fluoroquinolone antibiotic use for certain uncomplicated infections; warns about disabling side effects that can occur together. U.S. Food and Drug Administration (FDA). Silver Spring, MD. 2016. Available from URL: https://www.fda.gov/Drugs/DrugSafety/ucm500143.htm. As accessed January 2019.
4. U.S. Food and Drug Administration (FDA): FDA Drug Safety Communication: FDA updates warnings for oral and injectable fluoroquinolone antibiotics due to disabling side effects. U.S. Food and Drug Administration (FDA). Silver Spring, MD. 2016. Available from URL: https://www.fda.gov/Drugs/DrugSafety/ucm628753.htm. As accessed January 2019.
5. U.S. Food and Drug Administration (FDA): FDA Drug Safety Communication: FDA reinforces safety information about serious low blood sugar levels and mental health side effects with fluoroquinolone antibiotics; requires label changes. U.S. Food and Drug Administration (FDA). Silver Spring, MD. 2018. Available from URL: https://www.fda.gov/Drugs/DrugSafety/ucm611032.htm. As accessed January 2019.
6. U.S. Food and Drug Administration (FDA): FDA Drug Safety Communication: FDA warns about increased risk of ruptures or tears in the aorta blood vessel with fluoroquinolone antibiotics in certain patients. U.S. Food and Drug Administration (FDA). Silver Spring, MD. 2018. Available from URL: https://www.fda.gov/Drugs/DrugSafety/ucm628753.htm. As accessed January 2019.

HELLO, HEDIS

A quality start starts with you

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of health care's most widely used performance improvement tools. Most HEDIS and quality measures are measured from January 1 through December 31.

The goal is to provide patients with an excellent level of care while maintaining efficiency and financial balance.

Engage patients

- Remind patients to come in for their routine physical. Once the patient comes in for their appointment, it is important to assess if they are due for any quality measure services and administer them.
- Explain to patients how you and Cigna work together to improve their health.
- Convey why getting these services as scheduled is important.

Educate staff

It is encouraged to have at least one office staff member familiar with HEDIS and quality measures. This staff member can then educate other staff members and practitioners about:

- Which services patients need.
- How often services should be performed.
- Changes or updates to services.

Ensure correct coding

Now is also a great time to ensure that your systems and practitioners are submitting complete and correct coding that captures HEDIS services administered. When these services are correctly coded, it can prevent our quality department from having to request records and audit them to assess if quality

services were performed. During the course of the year, we may need to do a records collection for one of our quality auditing projects.

Have a plan in place

Now is also a good time to make sure you have a process in place for such records requests. Often, we send a representative to perform an onsite retrieval of records, so you may want to assign a work space, process, and contact person if someone comes to your office to collect records. The HEDIS project typically lasts about three months. The health plan collects data via records collection then submits the data to the state to receive scores for the quality measures. HEDIS measures and scores help keep providers and health plans accountable and responsible for the health of patients.

Reach out

For more information, visit https://www.ncqa.org/hedis/ or email our HEDIS Quality Improvement Manager, Ellena Melton, at **Ellena.Melton@Healthspring.com**.

CARE TRANSITION COORDINATION/ COMPLEX CASE MANAGEMENT

Who qualifies?

Care Transition Coordination (CTC)/Complex Case Management (CCM) is for patients who:

- Are **NOT** enrolled in a Disease Management Program, vendor program or reside in a nursing facility, regardless of impact risk, future risk score, or inpatient probability score.
- Have known multiple, serious, complex conditions with recent deterioration of health status that require acute inpatient and emergency room care.
- Have known complications in the past 90 days, self-care knowledge deficits and two or more of the following risk-screening criteria.
  - Nonadherence to prescribed chronic care medication.
  - Lack of a medical home for ongoing management of chronic condition or preventive care.
  - Lack of support system, or physical or cognitive or mental health impairments.
  - Social determents such as access to safe housing or shelter, food, community support, clothing or language/ literacy issues.
  - Need ongoing assistance with coordinating transportation, medical appointments and implementation of changes to the prescribed treatment plan.
  - A diagnosis listed below, in addition to one or more criteria above.
    - Posttransplant surgery
    - Post major surgical procedures
    - Posthospital, or receiving outpatient skilled nursing for non-diabetic wounds
    - Rare conditions such as sickle cell disease, hemophilia, etc.
    - New onset renal failure with new dialysis
    - S/P trauma secondary to an accident, including accidents in the home
    - Uncontrolled seizure disorders
    - Metastatic cancer

To learn more, call Service Coordination at 1-877-725-2688.

PSYCHIATRIC ADMISSIONS

Observation care and inpatient admission authorization

A majority of psychiatric admissions are for crisis stabilization. Many patients stabilize within 48 hours and only require observation.

Observation care is based on a specific set of clinically appropriate services that may include:

- Short-term treatment.
- Assessment.
- Reassessment.

After 48 hours of observation, the patient may face one of the following scenarios.

- Patient stabilizes >> discharge may be recommended.
- Patient continues to verbalize or demonstrate suicidal or homicidal ideation, or poses a danger to one's self or others >> inpatient hospitalization may be required.

When submitting an inpatient admission authorization request:

- Provider should submit all pertinent clinical data gathered in the first 48 hours that supports inpatient admission.
- If the clinical information supports inpatient admission, the authorization date begins on the first day of observation stay.
- If the clinical information supports observation, CHS will authorize observation.
- If provider agrees with recommendation for observation, provider must sign rescind letter canceling the inpatient request and return it to CHS.
- If provider disagrees with recommendation for observation, the inpatient request will be reviewed for medical necessity and provider will be notified of determination.

Reminders

- In-network facilities are not required to obtain an authorization for observation care.
- A facility cannot bill both observation and inpatient on the same day.

LONG-TERM SERVICES AND SUPPORTS

Changes to the billing matrix effective September 1, 2019

The STAR+PLUS Long Term Services and Supports (LTSS) billing matrix has been updated to:

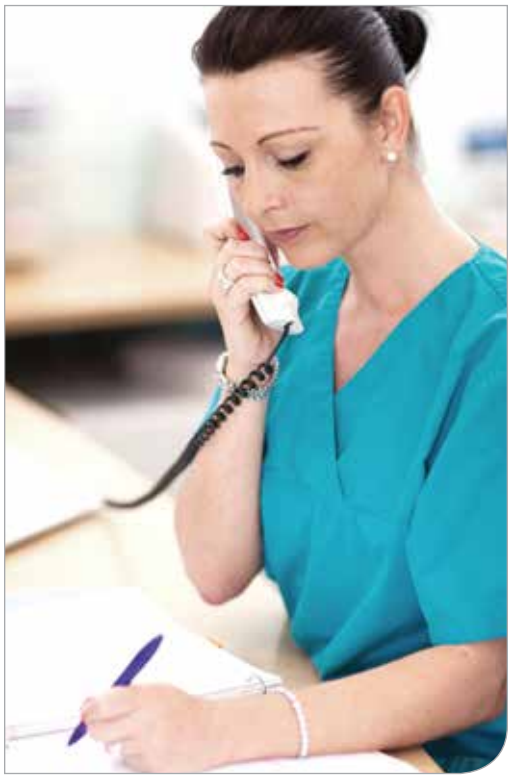
- Comply with electronic visit verification (EVV) standards.
- Comply with the National Correct Coding Initiative (NCCI) in Medicaid standards.
- Follow the billing structure outlined in the Texas Medicaid Providers Procedures Manual (TMPPM).

The new effective date to implement the EVV codes is September 1, 2019.

CURRENT CODE	CODE EFFECTIVE 9/1/2019	SERVICE DESCRIPTION	CURRENT UNIT INCREMENT	NEW UNIT INCREMENT
S5125	S5125 (no change)	Personal Assistance Services	1 hour = 1 unit	15 minutes = 1 unit
T2021	T2017 (NEW)	Habilitation	1 hour = 1 unit	15 minutes = 1 unit
S5151	T1005 (NEW)	Respite Care – In-home	1 hour = 1 unit	15 minutes = 1 unit

This billing matrix update reflects changes to:

- Personal Assistance Services (PAS) and Habilitation and Respite Care HCPCs codes.
- Units of service (i.e., 15-minute intervals).
- Changed STAR+PLUS Waiver to HCBS in the service descriptions.
- A legend of the HIPAA-compliant state-defined HCPCS modifiers for the EVV service descriptions.
- The HCPCS code for habitation, from **T2021** to **T2017**.
  - **T2021** is defined as a Day Habilitation, which is not an accurate description of the intended CFC service, habilitation. The **T2017** HCPCS code is defined as a Habilitation, Residential, Waiver, per 15 minutes. The code is being updated to reflect the actual service of habilitation.
- The in-home respite care HCPCS code, updated from **S5151** to **T1005**.
  - **S5151** is defined as Unskilled Respite Care, not hospice, per diem. The **T1005** HCPCS code is defined as a Respite Care Service, up to 15 minutes.



PRESCRIBING OPIOIDS

Know the limits

The relationship between elevated opioid dosage and adverse events, such as overdose, are a focus of the Centers for Disease Control and Prevention (CDC). Referencing multiple studies, the CDC recommends that clinicians should:

- **USE CAUTION** when prescribing opioids at any dosage.
- **CAREFULLY REASSESS** evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day.
- **AVOID INCREASING** dosage to ≥90 MME/day, or carefully justify a decision to titrate dosage to ≥90 MME/day.

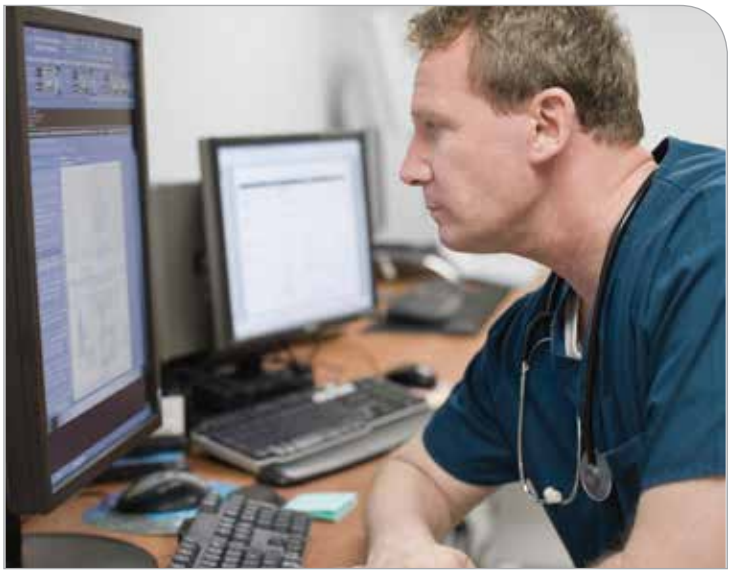
Accordingly, the Texas Health and Human Services Commission (HHSC) implemented a **cumulative MME limit of 90 MME/day** for all Texas Medicaid patients. As of January 28, 2019, Cigna-HealthSpring will follow the HHSC's opioid dosing parameters for Texas Medicaid patients.

Opioid claims exceeding the cumulative MME limit of 90 per day will require prior authorization (PA). Patients with a recent or current diagnosis of cancer will be excluded from such MME limits.

To initiate a PA request, contact Cigna-HealthSpring's Medicaid Pharmacy department. **Call 1-888-671-7379 or fax 1-888-766-6341.**

TEXAS MEDICAID

Credentialing verification organization



Please use the following resources for Texas credentialing verification organization (CVO).

NEW PAGE

Please refer to the Texas Association of Health Plans (TAHP) Credentialing Home Page. The page includes all the information you need to know about the CVO with Aperture Credentialing.

UPDATED

The **Information and Resources** section includes links to *Provider Contact Information, Presentations, Webinars, Aperture, Availity, Nursing Facility Resources and the Facility Credentialing Application*. In addition, it includes links to the form itself, instructions, and a secondary location addendum.

LINK COMPLETE

The link to the new TAHP CVO page is complete and the facility application and supporting documents are posted. It is ready to share or link to your own sites: http://texas-mco-directory.webflow.io/credentialing.

ELECTRONIC VISIT VERIFICATION UPDATE

New, up-front claims process to take place of retrospective process

Retrospective process

Valid for dates of service prior to June 1, 2019.

1. Cigna-HealthSpring (CHS) processes and reimburses EVV transactions.
2. CHS performs a retrospective review by comparing EVV transaction records against claim line items.
3. If EVV transactions don't match, provider is informed of the recoupment.

Up-front process

Effective June 1, 2019.

1. EVV claims will be evaluated up front. The following critical criteria must match the line items billed.
   - Member Medicaid ID
   - Provider NPI
   - HCPC code
   - Modifiers
   - Pay hours (must be exact match to units on claim per date of service)
2. If EVV data does not match the line items billed, the claim is denied prior to adjudication
3. Providers will receive notification via Explanation of Payment

Note: Date span billing will be allowed ONLY if you have an EVV transaction for each day within the date span on the claim line item.

Helpful hints

- Ensure EVV transactions are assigned to correct payer to avoid claim denial or recoupment.
- Check EVV vendor "failed to export" report for any failed transactions.
- Allow 48 hours for CHS to receive EVV transactions before submitting claim for payment.

To learn more, call Provider Services at **1-877-653-0331**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.

AUTHORIZATION REQUIREMENTS

Changes effective May 1, 2019

Authorization additions

- J1300, Eculizumab, 10 mg
- J9354, Ado-Trastuzumab Emtansine
- C9484, eteplirsen Exondys 51
- C9489, nusinersen, Spinraza
- Q2040, Tisagenlecleucel, Kymriah
- C9014, cerliponase alfa, Brineura
- C2098, inotuzumab ozogamicin, Besponsa
- Q2041, axicabtagene ciloleucel, Yescarta

Authorizations removed from requirements – Medical

- Oxygen
- Ambulatory blood pressure monitoring
- Sleep studies
- Enhanced External Counterpulsation (EECP)
- Hernia repairs
- Vagus nerve stimulations
- Wound care – outpatient setting
- Podiatry
- TMJ
- Cardiac rehabilitation
- Oral surgery

Authorizations removed from requirements – Behavioral Health

- Outpatient psychological and neuropsychological testing
- Neurobehavioral Assessment
- Outpatient electroconvulsive therapy (ECT)
- Residential detox
- Mental health rehabilitation
- Targeted Case Management

In-office labs removed from requirements

- 81007, Urinalysis; bacteriuria screen, except by culture or dipstick
- 84520, Urea nitrogen; quantitative
- 83026, Hemoglobin; by copper sulfate method, non-automated
- 84478, Triglycerides

continued on next page

AUTHORIZATION REQUIREMENTS *CONTINUED*

New lab codes providers can perform in their office without sending to an outside lab

- 81000, Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- 81015, Urinalysis; microscopic only
- 82043, Albumin; urine (e.g., microalbumin), quantitative
- 82247, Bilirubin; total
- 82271, Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; other sources
- 82465, Cholesterol, serum or whole blood, total
- 82565, Creatinine; blood
- 82948, Glucose; blood, reagent strip
- 82950, Glucose; post glucose dose (includes glucose)
- 82951, Glucose; tolerance test (GTT), 3 specimens (includes glucose)
- 82952, Glucose; tolerance test, each additional beyond 3 specimens (list separately in addition to code for primary procedure)
- 83037, Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
- 83655, Lead
- 84132, Potassium; serum, plasma or whole blood
- 85025, Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
- 87807, Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)

PEER SPECIALIST SERVICES TO BECOME A BENEFIT OF TEXAS MEDICAID

Effective for dates of service on or after January 1, 2019, peer specialist services will become a benefit for Texas Medicaid.

Overview of benefits

This new medical benefit policy includes the following.

- Covered benefits and limitations
- Peer specialist requirements
- Prior authorization requirements
- Documentation requirements
- Claim submission guidelines

Covered benefits

Peer specialist services are recovery-oriented, person-centered, relationship-focused, voluntary, and trauma-informed. Peer specialist services may include the following.

- Recovery and wellness support, which includes providing information on, and support with, planning for recovery
- Mentoring, which includes serving as a role model and providing assistance in finding needed community resources and services
- Advocacy, which includes providing support in stressful or urgent situations, and helping to ensure that the client's rights are respected. Advocacy may also include encouraging the client to advocate for him- or herself to obtain services

Peer specialist services are based on a mutual relationship between the peer specialist and the Medicaid-eligible client. A peer specialist uses his or her lived experience to support a client in achieving goals and objectives in the client's person-centered recovery plan, as well as skill development, problem-solving strategies, and coping mechanisms for stressors and barriers encountered when recovering from a mental health condition or a substance use disorder.

Services may be provided individually or in a group.

Peer specialist services (procedure code H0038) may be a benefit of Texas Medicaid

continued on next page

PEER SPECIALIST SERVICES *CONTINUED*

for clients who are age 21 and older with a mental health condition and/or substance use disorder, and who have peer specialist services included as a component of their person-centered recovery plan.

Benefit limitations

Reimbursement for procedure code H0038 will be limited to substance use disorders and mental health conditions, including, but not limited to, schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor related disorders, and feeding and eating disorders,

Procedure code H0038 will be limited to 104 units in a rolling six-month period. This limit may be exceeded with demonstrated medical necessity for the additional services.

Peer specialist services will also be limited as follows.

- May not be delivered simultaneously to other behavioral health services being delivered to an individual or group of individuals
- Must be delivered in person and not via advanced telecommunications technology
- When delivered in a group setting, limited to 12 total individuals per group session

Exclusions

The following services will not be benefits of Texas Medicaid.

- Record keeping or documentation activities
- Services provided without the client present

Peer specialist requirements

Peer specialists who are employed by the following Medicaid-enrolled providers may deliver peer specialist services as part of a coordinated, comprehensive, and individualized approach to treating a client's mental health condition and/or substance use disorder.

- Clinic or group practices treating behavioral health conditions
- Physicians (MDs), osteopaths (DOs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) treating behavioral health conditions

continued on next page

PEER SPECIALIST SERVICES *CONTINUED*

- Psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors
- Comprehensive provider agencies of targeted case management and mental health rehabilitative services
- Local mental health authorities and local behavioral health authorities
- Chemical dependency treatment facilities
- Federally qualified health clinics (FQHCs)
- Rural health clinics (RHCs)

Only clinic/group practices or individual health care provider (MDs, DOs, NPs, CNSs, PAs) with a behavioral health focus may be reimbursed for peer specialist services.

Non-Medicaid-enrolled providers who employ peer specialists may choose to enter into contract with one of the above Medicaid-enrolled providers to furnish peer specialist services as part of a continuum of comprehensive treatment services.

Providers of peer specialist services shall coordinate with all behavioral health service providers involved in the client's care, and utilize a person-centered, recovery-oriented approach to treatment planning and service delivery. Subcontracted peer specialist services must also be part of the coordinated, comprehensive, and individualized person-centered recovery plan.

A peer specialist must meet all of the following criteria.

- Be at least age 18
- Have lived experience with a mental health condition, substance use disorder, or both
- Have a high school diploma or General Equivalency Diploma (GED)
- Be willing to appropriately share his or her own recovery story with clients
- Be able to demonstrate current self-directed recovery
- Pass criminal history and registry checks as described in 1 TAC §354.3201

A peer specialist may not practice psychotherapy, make clinical or diagnostic assessments, or dispense expert opinions; engage in any service that requires a license; or falsify any documentation related to application, training, testing, certification, or services provided.

Certification

A peer specialist must complete all required training and certification before providing services.

continued on next page

PEER SPECIALIST SERVICES *CONTINUED*

To deliver peer specialist services, an individual must first complete required orientation and self-assessment activities as outlined in 1 TAC §354.3155, and then complete a core training delivered by a certified training entity.

On completion of the core training, supplemental training in one of the two following specialty areas must be completed.

- Mental health peer specialist
- Recovery support peer specialist

A person may apply for initial certification after successful completion of core and supplemental training and a knowledge assessment.

A peer specialist who is initially certified may begin to deliver Medicaid-covered services while participating in a supervised internship at their place of employment. The internship consists of 250 hours of supervised work experience that should be completed within a six-month period. An extension may be granted by the certification entity should a peer be unable to complete the required hours within the six-month timeframe.

Independent study, such as reading or watching instructional videos, does not count toward the required supervised work experience hours. Time spent receiving supervision, other than observation of the peer specialist providing services, does not count toward the required hours.

After completing the required internship hours, initially certified peer specialists may apply for renewed certification through the approved certified body. Certification must be renewed every two years, including any required continuing education hours.

Certified peer specialists should only deliver services within their specialty area.

Supervision

An organization in which peer specialists deliver services must provide supervision for peer specialists. Peer specialist supervision must be provided by one of the following.

- Qualified Credentialed Counselor (QCC) as defined in 1 TAC §354.3003
- Licensed Practitioner of the Healing Arts (LPHA) as defined in 1 TAC §354.3003
- Qualified Mental Health Professional (QMHP) as defined in 1 TAC §354.3003, with a QCC or LPHA supervising the QMHP
- Qualified Peer Supervisor (QPS) as defined in 1 TAC §354.3003, with a QCC or LPHA supervising the QPS

continued on next page

PEER SPECIALIST SERVICES *CONTINUED*

Peer specialist supervision must focus on a peer specialist's provision of services, including review of cases and activities, skill building, problem resolution, and professional growth. Supervision may also include aspects specific to the organization, such as following organizational policy or other administrative matters.

Peer specialist supervision may be provided as follows.

- Individually or in a group setting
- Face-to-face or via teleconference
- Include observation of the peer specialist providing services

Peer specialist supervision must occur at least once weekly for a peer specialist with an initial certification, at least once a month for a peer specialist with a two-year certification, or more frequently at the request of the peer specialist.

A QCC or LPHA supervising a QMHP or QPS must provide individual or group supervision at least once a month, and conduct an observation of the QMHP or QPS conducting peer specialist supervision at a frequency determined by the QCC or LPHA, based on the QMHP's or QPS's skill level.

A peer specialist supervisor must successfully complete supervisory training on peer specialist services and the recovery model from a certified training entity before supervising a peer specialist. Supervisor training must include all of the following.

- Clarification of the distinction between peer support and therapy
- The unique role of peer support in building and sustaining recovery goals
- Advocating for peer specialists and peer specialist services
- Providing strengths-based, timely, and respectful feedback about the peer specialist's job performance
- Basic skills in supervising others, such as working with a variety of personality types and communication styles

After completing training, each prospective supervisor must successfully complete a knowledge assessment before a certified training entity approves him or her to supervise certified peer specialists. Peer specialist supervisor certification must be renewed every two years, including any required continuing education

continued on next page

PEER SPECIALIST SERVICES *CONTINUED*

hours.

Prior authorization (fee for service)

Prior authorization is not required for the first 104 units of peer specialist services in a rolling six-month period. Prior authorization is required once an individual exceeds 104 units of individual or group peer specialist services in a rolling six-month period.

Prior authorization requests for procedure code H0038 must be submitted to TMHP using the Special Medical Prior Authorization (SMPA) Request Form. Requests for continued services should demonstrate all of the following.

- The individual continues to meet eligibility criteria as outlined above, including current DSM diagnosis codes
- Current person-centered recovery plan and goals
- Progress made, relative to the goals outlined in the person-centered recovery plan
- The need for continued services

Requests should indicate how many additional units of service are being requested (up to 30 units are allowed per request) and which type (individual and/or group), as well as an expected timeframe when services will be delivered.

Note: *The requesting provider may be asked for additional information to clarify or complete a request.*

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested service.

Documentation requirements

The Medicaid-enrolled provider must ensure proper documentation of all peer specialist services delivered. Documentation of peer specialist services must indicate the date, time, and place of service. The documentation must summarize the purpose and content of the services, along with specific strategies and activities utilized as related to the goal(s) in the client's plan of care.

Peer specialist supervisors must document all supervisory sessions and maintain records in the peer specialist's employee personnel file.

continued on next page

PEER SPECIALIST SERVICES *CONTINUED*

Claim submission guidelines

Procedure code H0038 must be submitted with one of the following modifiers to identify the specialty focus.

- Modifier HE – mental health
- Modifier HF – substance use

If services are provided in a group setting, procedure code H0038 must also be submitted with modifier HQ.

Mental health rehabilitative services are billed separately from peer specialist services.

FQHCs and RHCs should submit claims using H0038 for informational purposes only.

OUR BRAND IS EVOLVING

Cigna-HealthSpring is changing to Cigna

Exciting news. We're embarking on a new chapter of our Medicare business. We've made the decision to evolve our current name, Cigna-HealthSpring, to Cigna.

While this transition will not impact the current day-to-day business operations for your practice, you will start to see the Cigna logo on all patient and provider-facing communications starting this year and into 2020. This will impact our Medicare Advantage, Part D, TX STAR+PLUS, and TX CarePlan Medicare-Medicaid lines of business. Our specific plan names are not changing at this time, so you will continue to see Cigna-HealthSpring in our plan names.

Uniting our organization under a single name and well-known brand positions us best to deliver on our corporate mission: improving the health, well-being and peace of mind of those we serve. This also creates a seamless brand experience for our customers throughout their health journey. Please reach out to your Network Operations Representative if you would like to know more.

The Cigna-HealthSpring brand has served us well and will always be a significant part of our history. Our name may be changing, but our commitment to patients and providers stays the same.

Thank you for being part of who we are.

Together, all the way.®

CMS PRECLUSION LIST

Quickfire Q&A

As of January 1, 2019, the Centers for Medicare & Medicaid Services (CMS) started publishing a monthly Preclusion List.

Q: What is the CMS Preclusion List?

A: A list of providers and prescribers precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Q: What is its impact?

A: Part D sponsors must reject pharmacy claims (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List. MA plans must deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

Q: Who is on the list?

A: Individuals or entities who:

- Are currently revoked from Medicare, are under an active re-enrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

  CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

Q: Are providers or entities notified when they are placed on the Preclusion List?

A: Yes. In advance of inclusion on the list, CMS sends an email and letter to the:

- Provider Enrollment Chain and Ownership System (PECOS) address, or
- National Plan and Provider Enumeration System (NPPES) mailing address.

  The letter includes the reason for the preclusion, the effective date of the preclusion, and applicable rights to appeal.

For more information, visit www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html.

NETWORK INSIDER

Spring 2019

H8423_19_74903_PR 06042019 929025

<Name>
<Address>

500 Great Circle Road
Nashville, TN 37228

Cigna HealthSpring CarePlan

TEXAS Medicaid PLAN
Su Plan de Salud ★ Su Opción

TEXAS Health and Human Services

NETWORK INSIDER

Spring 2019