ConnectiCare

April 2017 - In this issue

Preventive services: 2017 policy and coding updates effective May 1, 2017

We're making other updates to our preventive services guidelines for diagnostic mammography, colon cancer screening, assessment for fall prevention and immunizations. These updates will only apply to commercial members with individual and group plans who receive the services from in-network

ConnectiCare health care providers. These changes do not affect your patients with employer-sponsored plans for municipalities.

- **Mammography:** We will no longer accept diagnostic mammography codes as preventive services without member cost-shares.
  - Mammography as a preventive service will be limited to screening mammography codes CPT 77067 or G0202 until Dec. 31, 2017.
  - HCPCS codes G0204 and G0206 are diagnostic and not included in screening mammography as of Jan. 1, 2017.

- **Colon cancer screening:** We will limit the sigmoidoscopy procedures we accept as preventive and will add computed tomographic (CT) colonography as a preventive service in appropriate circumstances.
  - Sigmoidoscopy procedures included under colon cancer screening will be limited to CPT codes 45330, 45331 and 45333.
  - We will add CT colonography, also known as virtual colonoscopy, CPT code 74263, as a preventive service, but preauthorization for the service will be required.

- **Physical therapy for fall prevention:** This preventive service will be changed to "assessment for fall prevention."
  - The assessment codes under this service will be included under the annual preventive screening service.
  - Any physical therapy after the assessment will not be considered preventive and a member cost-share will apply.

- **Medical nutrition therapy:** We will be adding CPT code G0270, medical nutrition therapy by a telehealth provider, as a preventive service without cost-share.

- **Immunizations:** We will be updating our preventive vaccine codes to include new codes and remove obsolete ones.

Hospital-grade breast pumps will be available as preventive service

We're expanding our existing breast pump preventive service to include a hospital-grade breast pump, CPT code E0604, as of May 1, 2017. This will affect your patients with ConnectiCare commercial plans. You'll need to seek preauthorization approval before you can prescribe it to your commercial patients.

If we preauthorize the hospital-grade breast pump, your female patient will have no out-of-pocket costs as long as the following guidelines are followed:

Date of service: on or after May 1, 2017
Provider: participating in ConnectiCare network
Procedure code: E0604
Frequency: one per 10 rolling months
Age Band: All
Gender: F

If the above guidelines are not followed, the in-network durable medical equipment cost-share will apply. If an out-of-network provider provides the breast pump, the patient will need to pay the out-of-network durable medical equipment cost-share.

Flu coverage will include new vaccine after July 1

We will cover a newly available flu vaccine, CPT code 90682, for any dates of service on or after July 1, 2017. We will cover this vaccine for both our commercial and Medicare plans.

For most ConnectiCare members, there is no copayment, coinsurance or deductible if the only reason for a visit is to get a flu shot. If there is an additional, separate reason billed for a visit, copayments, coinsurance and/or deductibles will apply.

If a member receives a flu vaccination from a non-participating provider, we will cover the usual-and-customary amount.

If a commercial member pays for the immunization out of pocket, he or she can provide a receipt to ConnectiCare along with a completed Out-of-Plan Reimbursement Form. Medicare members should use this Medicare Out-of-Plan Reimbursement Form.

Our up-to-date telemedicine policy

Here's ConnectiCare's policy on the use of communication technologies to diagnose and treat patients.

Medicare news: Treatment of dual-eligible patients

Something to keep in mind: patients who are eligible for both Medicare and Medicaid and designated as Qualified Medicare Beneficiaries (QMBs) cannot be billed for any Medicare cost-share, including deductibles, coinsurance and copayments. Federal law prohibits balance billing of these patients.

This applies to **all Medicare providers** regardless of whether they accept Medicaid.

The QMB program is a Medicaid program that exempts Medicare beneficiaries from having to pay their Medicare cost-share. If providers want to get paid for the patient's cost-share, the bill of service may be submitted to Medicaid for reimbursement.

For more information, please go to this Medicare Learning Network resource.

Recent provider headlines

Check out the latest Provider News & Headlines:

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