ConnectiCare

December 2017 - In this issue

What's new for 2018?

Here’s what you need to know about policies and changes effective Jan. 1, 2018, plus updates on pharmacy, coding and product changes:

Magellan Rx to manage preauthorization review for IVIG, SCIG and Remicade products

ConnectiCare has contracted with Magellan Rx Management (Magellan Rx) to manage the review of preauthorization requests for the following specialty drugs:

- Intravenous Immunoglobulin (IVIG)
- Subcutaneous Immunoglobulin (SCIG)
- Remicade® (infliximab)
- All Remicade's biosimilar products

This is effective Jan. 1, 2018, for all our Medicare Advantage and commercial plans, including individual and group plans purchased through the state insurance exchange, Access Health CT.

Magellan Rx, the pharmacy benefit management division of Magellan Healthcare, has more than 12 years of experience in specialty pharmacy and medical drug benefit management, and has clinical pharmacists and physicians available to ConnectiCare providers as resources.

If you have commercial or Medicare patients who are scheduled to receive any of the drugs listed above on or after Jan. 1, 2018, you must obtain preauthorization for those treatments from Magellan Rx. Through this preauthorization program, Magellan Rx may also direct commercial members to an alternative site of service, when appropriate.

To make sure your patients' treatments continue without interruption, you can start submitting preauthorization requests to Magellan Rx starting Dec. 26, 2017. You can submit:

- Routine requests through Magellan Rx's secure website at ih.MagellanRx.com (registration and log in required).

- Urgent requests by calling Magellan Rx at 1-800-424-8323 from 8 a.m. to 6 p.m. (ET) Monday through Friday.

If providers do not obtain preauthorization for IVIG, SCIG, Remicade or all Remicade's biosimilar products from Magellan Rx after Jan. 1, 2018, claims may be denied.

Claims and appeals processes are not changing: please continue to submit claims, claims questions and appeals to ConnectiCare.

Part B drug benefit for Medicare members will require preauthorization in 2018

We will require preauthorization for some drugs covered under the Part B drug benefit for Medicare Advantage members starting Jan. 1, 2018. This policy is consistent with the preauthorization process now in place for ConnectiCare commercial plans, including individual and group policies.

Here's a list of drugs that will require preauthorization and where you will submit requests.

Depending on the drug, preauthorization requests will be reviewed by us or by one of our partners, New Century Health (NCH) or Magellan Rx Management (Magellan Rx).

- **New Century Health** — Submit requests by:
  - Going to my.newcenturyhealth.com (log-in required), or
  - Calling NCH's Utilization Management Intake department at 1-888-999-7713, option 1, 8 a.m. to 8 p.m. (ET) Monday through Friday.
- **Magellan Rx Management** — Submit:
  - Routine requests through **ih.magellanrx.com** (log-in required), or
  - Urgent requests by calling Magellan Rx at 1-800-424-8323, 8 a.m. to 8 p.m. (ET) Monday through Friday.
- **ConnectiCare** — Submit requests in writing by using this form and then:
  - Fax: 1-877-300-9695
  - Mail: ConnectiCare
    Attn. Pharmacy Services
    55 Water Street
    New York, New York 10041

2018 formulary changes for Medicare Advantage plans

We've written to Medicare Advantage members with Part D coverage who may be affected by changes in how drugs are covered starting Jan. 1, 2018. We urged them to talk to their doctors about any possible prescription changes they may need before the new year.

Please support your patients who may be affected by:

- Anticipating any changes in medications that may be needed,
- Answering your patients' questions, and
- Writing new prescription orders for them, when needed, before Jan. 1.

The changes to the formulary effective Jan. 1, 2018, will be:

Drugs no longer covered:		
ABILIFY	DESONIDE	NITROSTAT
ACETAMINOPHEN-CODEINE SOLUTION	ENABLEX	PATADAY
AGGRENOX	EPZICOM	PREDNICARBATE
ALPRAZOLAM ER	FLUOCINOLONE ACETONIDE 0.01% and 0.025% CREAM	PRISTIQ ER
ALPRAZOLAM XR	FLUOCINONIDE-E	SEROQUEL XR
AZILECT	GALANTAMINE ER	SIMBRINZA
BENICAR	GLEEVEC	STRATTERA
BENICAR HCT	HALOBETASOL PROPIONATE	TAZORAC
BETAMETHASONE DIPROPIONATE AUGMENTED	KLOR-CON M10	TEGRETOL XR
BETOPTIC S	MIRTAZAPINE ODT	TIKOSYN

BYETTA	NAMENDA	VOLTAREN GEL
CLOTRIMAZOLE 1% SOLUTION	NASONEX	VYTORIN
COPAXONE	CRESTOR	XARELTO

Drugs moving to a higher tier:		
CLARAVIS	JANTOVEN	MOMETASONE FUROATE 50 MCG SPRAY
DICLOFENAC SODIUM GEL and TOPICAL SOLUTION	LEVOXYL	OLOPATADINE HCL

Drugs that will require preauthorization:	
BUTALBIT-ACETAMINOPHEN-CAFF CP	BUTALBITAL-ASA-CAFFEINE CAP

Drugs added to formulary:	
CIPRODEX	EPINEPHRINE AUTO-INJECT
CORLANOR	NARCAN
COSENTYX PEN	

Drugs moving to a lower tier:		
AMLODIPINE BESYLATE-BENAZEPRIL	ENOXAPARIN SODIUM	METHOTREXATE 2.5 MG TABLET
AMOXICILLIN	FOSINOPRIL SODIUM	QUINAPRIL HCL
BENAZEPRIL-HYDROCHLOROTHIAZIDE	FOSINOPRIL-HYDRO	QUINAPRIL HYDROCHLOROTHIAZIDE

HYDROCHLOROTHIAZIDE	CHLOROTHIAZIDE	HYDROCHLOROTHIAZIDE
CEPHALEXIN	HYDROXY CHLOROQUINE SULFATE	REPAGLINIDE
ENALAPRIL MALEATE	IRBESARTAN	VALSARTAN
ENALAPRIL-HYDROCHLOROTHIAZIDE	IRBESARTAN-HYDROCHLORO THIAZIDE	VALSARTAN-HYDROCHLORO THIAZIDE

Medical criteria for Dexilant will change after Jan. 1; new preauthorization requests required

We are updating our medical criteria for Dexilant (dexlansoprazole) on Jan. 1, 2018, for all our individual members with commercial plans bought on and off the state insurance exchange, Access Health CT.

We have notified members affected by this change and suggested they reach out to their doctors to get new preauthorization requests for Dexilant submitted to ConnectiCare after Jan. 1, 2018.

We will only cover Dexilant, if doctors document that the patient has tried **all of the following alternatives** to Dexilant without success:

- Nexium OTC
- Omeprazole
- Pantoprazole
- Lansoprazole

Without a new preauthorization, we will not cover Dexilant and your patient will be responsible for the full cost of the drug. Doctors can fax a preauthorization request to ConnectiCare at 800-249-1367.

Passage referral plan changes for 2018

Our "Passage" referral plans are now available to more commercial and Medicare Advantage members and more PCPs will be accepting the plans. Here's the Passage article from the November 2017 *Office Visit* if you need to refer to it again.

PCPs, please note:
Remember, if you are not designated as a Passage PCP, you should not provide primary care services to members with Passage plans. If you do provide such services, we will deny claims and tell members they are responsible for the costs. (For Passage members with individual plans through Access Health CT, the Connecticut insurance exchange, the claims will be paid under their out-of-network benefits.)

Specialists, make checking referrals a practice:
Check our website, connecticare.com/providers, to see if your Passage patients have a PCP referral for your specialty care. *Passage members can see any specialist in the ConnectiCare network as long as they have* ***valid referrals from their Passage PCPs for each specialist.***

Expect your patients with Passage plans to ask you to confirm that their referrals remain valid before they have visits. Without referrals, we will deny claims for specialists' consultation services and tell members they are responsible for the costs.

Referrals are not required when Passage members need hospital and/or ancillary care services, such as radiology and lab work.

Updated ID cards for your patients with plans purchased through Access Health CT

We've updated our 2018 ID cards for your patients with individual and small group plans purchased through Access Health CT, the state insurance exchange. Here's the latest design:

Top of updated Member ID card

New 2018 codes

Each year billing codes are updated by the American Medical Association. Please refer to the 2018 manuals for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) as resources.

We're updating our system for new 2018 codes. Claims submitted with new codes for covered services will be noted on the explanation of payment (EOP) statements with an explanation code of Z0 that states "New code, rate not yet established, will be adjudicated by March 31, 2018." This applies to commercial and Medicare plans.

We will automatically adjust claims with new, covered codes that are submitted between January and March 31, 2018. Providers do not need to resubmit claims. When the adjustments are made and claims paid, EOPs will inform providers that the payment includes adjustment of the new codes that paid $0 upon initial submission.

Claims edits that will go into effect Feb. 27, 2018

Policy	Description	What plans are affected?
Canalith repositioning procedure	Canalith repositioning procedure CPT code 95992 will be reimbursed only when billed with benign paroxysmal vertigo diagnoses as indicated on the NGS Medicare LCD L33631.	Commercial and Medicare Advantage
Cosyntropin (J0833, J0834)	J0833 or J0834 are payable when billed with a diagnosis code supported by an FDA-approved indication or an approved off-label indication. *Source: FDA package insert*	Commercial and Medicare Advantage
Iontophoresis	Iontophoresis procedure CPT code 97033 will be reimbursed only when billed with diagnoses for primary focal hyperhidrosis as indicated on the NGS Medicare LCD L33631.	Commercial and Medicare Advantage
Iron Sucrose (J1756)	J1756 is payable when billed with a diagnosis code supported by an FDA-approved indication or an approved off-labeled indication. *Source: FDA package insert* J1756 is payable when billed with a diagnosis of chronic kidney disease and a diagnosis of anemia in chronic kidney disease. *Source: ICD-10 Manual* J1756 is limited to 200 combined units per date of service by any provider when the diagnosis on the claim is iron deficiency anemia associated with chronic heart failure, iron deficiency anemia due to malabsorption disorders, or iron deficiency anemia of pregnancy. *Source: Thomson Micromedix Drugdex*	Commercial and Medicare Advantage

Place of Service Coding for Physician Services	Professional claims for services performed in a facility place of service are to be submitted with the appropriate place-of-service code. If a professional claim is billed with a non-facility place of service, and a facility claim is received for the same procedure, the professional claim will be denied and should be resubmitted with the appropriate facility place of service code.	Commercial only
Anesthesia for Pain Management Injections	Anesthesia and moderate sedation services (00300, 00400, 00600, 01935-01936, 01991-01992, 99152-99153, 99156-99157) when billed with pain management services, are payable only when billed and a surgical procedure (CPT 10021-69990) has been billed by any provider for a patient age 18 or older. *Source: The American Society of Anesthesiologists Pain Medicine Committee*	Commercial only
Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy	Nerve conduction study (CPT 95905) is payable only when billed with a needle electromyography (95860-95864) if the only diagnosis on the claim is radiculopathy. Nerve conduction study (CPT 95907-95913) is payable only when billed with a needle electromyography (95885, 95886) if the only diagnosis on the claim is radiculopathy. Needle electromyography (95860-95864) is payable only when billed with a nerve conduction study (95905) if the only diagnosis on the claim is radiculopathy.	Commercial only

	Source: American Association of Neuromuscular and Electrodiagnostic Medicine	
Omalizumab (J2357)	J2357 is limited to 75 combined units per date of service by any provider when the diagnosis is moderate to severe persistent asthma. *Source: FDA package insert*	Medicare Advantage only

ConnectiCare voted as "Best Health Insurance Provider" in the Hartford region

Readers polled by ***The Hartford Business Journal*** chose ConnectiCare as the "Best Health Insurance Provider." Read the HBJ article.

Provider service hours during the holidays

Our regular provider service hours are 8 a.m. to 6 p.m. Monday through Friday. This holiday season we are closing on the following days so our representatives can spend time with their families and friends:

- Monday, Dec. 25: closed
- Monday, Jan. 1: closed

We will be taking provider calls on Friday, Dec. 22, from 8 a.m. to 6 p.m.

Recent provider headlines

Check out the latest Provider News & Headlines:

- Passage referral plans expanded for our commercial and Medicare members
- OTC drugs will no longer be covered after Jan. 1 for Exchange plans
- Online provider directory updated: Check your information
- New ConnectiCare blog, a resource for your patients

Keep in Touch