ConnectiCare

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Submit taxonomy codes to make sure claims are paid correctly

Here's a tip that can make a difference in how quickly your claims are paid: submit your taxonomy codes in both your paper and electronic claims submissions. Taxonomy codes allow your claims to be priced according to the Centers for Medicare & Medicaid Services' established rates. The **submission of taxonomy codes is required for all Medicare claims submissions**, and it is *highly recommended* for commercial claims.

Reminder: Use new Medicare Advantage ID numbers

All ConnectiCare Medicare Advantage patients have new identification cards with new ID numbers. Please use those new ID numbers for any date of service after Jan. 1, 2017, to avoid claim denials.

- The member identification (ID) numbers on newly issued cards (Ex. M99988877701) (See samples of new cards.)
- Payer ID number 78375

For more information about how to submit Medicare claims submission, you can read this Provider Headline article.

Claims payment policies updated as of Jan. 31, 2017

We have made a number of updates to our claims payment policies that went into effect with claims processed on and after Jan. 31, 2017. The updates apply to commercial and Medicare Advantage plans, unless otherwise specified.

The updates are:

Topic	Instructions for claims payment submission

ICD-10	ICD-10 diagnoses codes are required to be reported in accordance with guidelines set by the Centers for Medicare & Medicaid Services (CMS) and National Government Services (NGS) Medicare and noted in the ICD-10 manual. • Bill with the code to the highest specificity. • Manifestation or secondary diagnoses codes cannot be the only code on a claim. • Encounter diagnoses codes for chemo or immunotherapy administration procedures must be reported with a primary diagnosis for which treatment is needed.
Drugs and Biologicals	The following drug and biological code edits will apply: • J0881, J0885 or J0888 will not be payable when billed with modifier EC, and the diagnosis associated to the claim line is not approved for ESA treatment. • J9041 will be limited to 32 combined units per date of service by any provider when billed and the diagnosis is mantle cell lymphoma or multiple myeloma. • J0178 is payable with a diagnosis of diabetic macular edema when diabetic retinopathy or diabetic macular edema and diabetes mellitus with ophthalmic manifestations is also present. • J0897 is payable when billed with a diagnosis for a Food and Drug Administration-approved indication or an off-labeled indication. • J0897 will be limited to 60 combined units per date of service by any provider when the diagnosis is not adults and skeletally mature adolescents with giant cell tumor of bone, hypercalcemia of malignancy refractory to bisphosphonate therapy or

	prevention of skeletal-related events in patients with bone metastases from solid tumors. • J0881, J0885 or J0888 will be required to be billed with modifier EA, EB or EC as applicable. • **Medicare Advantage only:** J9310 will be limited to 10 combined units per date of service by any provider when A9542 (Indium In-111 ibritumomab tiuxetan, diagnostic) or A9543 (Yttrium Y-90 ibritumomab tiuxetan, therapeutic) has not been billed for the same date of service, and the diagnosis is not chronic lymphocytic leukemia, minimal change disease, or systemic lupus erythematosus. • **Medicare Advantage only:** J9310 will be limited to eight times in a patient's lifetime when billed by any provider and the diagnosis is acute lymphocytic leukemia, benign mucous membrane pemphigoid, Burkitt's lymphoma, chronic graft-versus-host disease, multicentric Castleman's disease, pemphigus foliaceus or pemphigus vulgaris.
Cardiology	93260-93261, 93282-93284, 93289, 93292 or 93295 (Automatic implantable cardiac defibrillator [AICD] monitoring) will be allowed when billed up to once per three months when the diagnosis is ICD-10 code Z95.810 (Presence of automatic [implantable] cardiac defibrillator).
Chiropractic	• **Medicare Advantage only:** Chiropractic manipulation (98940-98942) will be payable when billed with modifier AT. • **Medicare Advantage only:** Chiropractic manipulation (98940-98942) will be payable only when billed with a primary diagnosis of subluxation and a secondary diagnosis for the symptoms

	associated with the diagnosis of subluxation is not present.
Immunization Services	• **Medicare Advantage only:** G0008, G0009, G0010 will be required to be billed with the appropriate, corresponding vaccine code. • **Medicare Advantage only:** Immunization administration (90460-90461, 90471-90474) will be required when billed with a vaccine/toxoid code (90476-90749, J3530, Q2033-Q2039, or S0195 (if code is allowed).
Ophthalmology	Fundus photography (92250) will be allowed when billed up to two units within one year, except when specific diagnoses are present.
Physician Services	• Hospital discharge services (99238-99239) will be payable once per member for the same date of service. • Transitional care management (TCM) services (99495-99496) will be payable once per member for the same date of service. • Evaluation and management services not indicated as being for a significantly separately identifiable unrelated reason will not be payable when billed with cardiovascular services. • Services billed for locations 19 (outpatient hospital - off campus), 22 (outpatient hospital - on campus) or 23 (emergency room - hospital) billed by any provider on the same date where the member is inpatient the day before and the day after, will not be reimbursed.
Professional Component	One professional component may be reimbursed per code for the same service when billed by different providers.

	Multiple interpretations of the same service are not payable.
Surgery	• Knee arthroscopy lavage and/or debridement procedures will be payable with a diagnosis other than osteoarthritis of the knee. • Procedures billed without modifier 54, 55 or 56 when another provider has billed the same procedure with modifier 54, 55 or 56 will not be paid separately.

Commercial medical record reviews have started

From now through April, you may receive a call from Inovalon about reviewing the medical records of your patients with ConnectiCare commercial plans, including plans purchased on Access Health CT, the Connecticut exchange.

Inovalon will conduct chart reviews on our behalf as part of the 2016 benefit year review of medical records. As a health plan, we must submit detailed documentation for each patient on an ongoing basis to the U.S. Department of Health and Human Services (HHS). All charts must be received at Inovalon by April 15, 2017.

Inovalon will contact you to arrange a convenient way of obtaining copies of our members' medical records for dates of service in 2016. As our partner and "business associate," as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Inovalon is fully HIPAA compliant and is required to protect, preserve and maintain the confidentiality of any protected health information (PHI) it obtains from clinical records provided by medical practices.

We truly appreciate your help with this medical records review. If you have questions, please call a ConnectiCare provider education and service representative at (860) 409-2468. Notice of the need for these reviews and your

required compliance are included in your contractual agreement with ConnectiCare.

Recent provider headlines

Check out the latest Provider News & Headlines:

- 2017 codes updated
- Need to check benefits and eligibility of your Medicare Advantage patients? Go online or go through your EDI system
- Annual HEDIS data collection to start in February
- Make sure we have current information for our provider directory

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