ConnectiCare

June 2017 - In this issue

Consult codes will remain on the schedule for commercial plans

Consultation codes for ConnectiCare commercial plans, including plans purchased through the Connecticut exchange, Access Health CT, **will continue to be reimbursable** to participating and non-participating providers. We heard your concerns and we have reconsidered the change we reported in last month's Office

Visit. As a reminder, our existing 2010 policy for ConnectiCare Medicare Advantage plans remains unchanged.

Telephone outreach to confirm your practice information will start this month

We've hired Atlas Systems to contact all our commercial and Medicare Advantage providers to confirm the practice information for our online and printed provider directories. Expect to hear from Atlas Systems starting this month.

Members rely on our provider directory, and it is critical to ensure that it includes the correct information on your practice — including hours, phone number, website, locations and whether accepting new patients.

Atlas will use telephone calls and/or fax requests to your office. They will also send a letter with instructions for confirming information online using Atlas Systems' PRIME-Hub.

Please respond promptly to the request from Atlas.

Medical record reviews start this month

From now through December, you may receive separate requests from Inovalon and/or Health Data Vision, Inc. to review the medical records of your patients who have ConnectiCare Medicare Advantage or commercial plans.

Inovalon, which has done previous outreach for us, will conduct chart reviews of dates of services in 2016 for both our commercial and Medicare Advantage plans.

We must submit accurate and complete member diagnosis data to the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS). Inovalon will call your offices to coordinate a convenient chart retrieval method and specify the date by which records must be

received.

Health Data Vision, Inc. (HDVI), will also contact some provider offices to retrieve, review and submit the medical records for members identified by CMS as part of the annual audit of ConnectiCare.

CMS conducts an annual audit to verify the accuracy of diagnosis data that health plans submit to HHS. We are required to submit supporting medical records on CMS' audit population. HDVI will call your offices to coordinate a convenient chart retrieval method and specify the date the records must be received.

Please respond to HDVI's and Inovalon's request for records promptly.

As our partners and "business associates," as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), both HDVI and Inovalon are fully HIPAA compliant and are required to protect, preserve and maintain the confidentiality of any protected health information (PHI) obtained from clinical records provided by medical practices.

We truly appreciate your help with these medical record reviews. 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.

Understanding the provider medical necessity appeals process for Connecticut commercial members

Here's a refresher for your office, should you disagree with a decision we make to deny payment for an admission, service or procedure, or decide against extending an already authorized inpatient stay. In those instances, you can go through our one-level provider medical necessity appeal process.

Here are the following circumstances that an in-network provider may request a medical necessity appeal:

- urgent/emergent situation — the patient's condition was such that there was insufficient time to obtain preauthorization
- the member did not provide correct insurance information to the provider
- ConnectiCare did not provide correct information to the provider
- if allowed in the Provider Contract language

A provider may file an appeal to ConnectiCare verbally, in person, in writing or electronically (by fax or by email). But remember, an appeal needs to be initiated no later than 180 calendar days after we made the initial decision or when the claim was denied, whichever comes first.

When we receive an appeal, we will send it to an Independent Review Organization (IRO) for review by physician specialists who are:

- in the same or similar specialty as the physicians that would typically provide treatment;
- not involved in the initial adverse benefit determination; and,
- not a subordinate of any person involved in the initial adverse benefit determination.

A provider will receive written notification of the appeal decision according to regulatory time frames:

- 30 days for pre- and post-service appeals
- 45 days if additional information is needed

If the IRO overturns our decision, we will provide coverage or payment based on the IRO's determination.

Provider resources for your patients struggling with addiction

Drug overdoses are now the leading cause of death among Americans under age 50.[1] Do you have patients struggling with addiction? If so, here are some

resources that may be useful from Optum, the company that manages and administers our behavioral health program:

1. Pocket Guide for Opioid Prescribing: Adapted from Centers for Disease Control and Prevention guidelines
2. Medication-Assisted Treatment Can Improve Health Outcomes
3. Clean Slate: A new medication-assisted treatment provider in Hartford
4. Relias Learning: CME Courses with a specific focus on addiction and Opioid Use Disorder

[1]Katz, Josh. "Drug Deaths in America Are Rising Faster Than Ever." *The New York Times*. 05 June 2017. Web. Accessed 13 June 2017.

Recent provider headlines

Check out the latest Provider News & Headlines:

- New diagnosis-related group (DRG) readmission policy
- Members may be calling you to close gaps in care
- Is there anything new with your practice? We want to know.

Follow Us