ConnectiCare

April 2018 – In this issue

Passage PCPs and specialists: download this list of specialties that need referrals

Your patients with commercial and Medicare Advantage Passage plans need Passage primary care provider (PCP) referrals to visit certain specialists. Here's a list of specialties that need referrals.

Answers to Passage Plan FAQs are also on our website.

Notice of Medicare Non-Coverage requirements: SNFs and home health providers

Skilled nursing facilities and home health care providers must give the Notice of Medicare Non-Coverage (NOMNC) letter to Medicare Advantage patients in a timely fashion. This informs a Medicare beneficiary when services are ending and his/her rights on appealing the decision.

The Centers for Medicare & Medicaid Services says the NOMNC must be provided to and signed by the Medicare beneficiary in the following timeframes:

- If care is provided daily — At least two calendar days before the covered services end.
- If care isn't provided daily — The second to the last day when the Medicare-covered services is provided.
- If care is expected to take less than two calendar days — At the time of admission.

There are some exceptions to the NOMNC requirements. The notice doesn't have to be provided to beneficiaries if they use up all their benefits, when they move to a higher level of care or when they don't receive Medicare services in a covered setting. Please refer to this CMS document for details.

To help ensure timely delivery of the NOMNC, we encourage providers to provide the notice to our Medicare Advantage members **as soon as they know when the services will end.**

Please refer to the CMS website for details on the NOMNC form and how to properly fill it out. The information you will need specific to ConnectiCare is:

- ConnectiCare is in Quality Improvement Organization (QIO) Area 1
- The QIO name and contact numbers: Livanta, phone 1-866-815-5440, TTY: 1-866-868-2289
- Medicare plan contact information: ConnectiCare, phone 1-800-224-2273

When our partner, CareCentrix manages post-acute care of Medicare members, providers must submit requests for reauthorization of services to CareCentrix **at least 72 hours before** the existing authorization of services expires.

New Medicare cards rolling out

Newly eligible Medicare beneficiaries are receiving the newly designed Medicare ID cards from the Centers for Medicare & Medicaid Services (CMS). Existing Medicare beneficiaries in Connecticut will get new cards sometime after June 2018.

CMS is issuing new cards to remove Social Security numbers (SSNs) by April 2019. The new cards are for original Medicare and do not apply to Medicare Advantage plans, like the ones ConnectiCare offers. ConnectiCare Medicare Advantage ID cards do not use or include Social Security numbers (SSNs).

The new Medicare cards will have new Medicare Beneficiary Identifiers (MBIs) that replace the SSN-based Health Insurance Claim Numbers (HICNs) used for Medicare transactions, like billing and claim status. The new MBIs should be treated like personal health information.

To find out more, check out these resources from CMS:

- What do the new Medicare cards mean for providers?

- New Medicare Card Project: Frequently Asked Questions (FAQs)

Providers can also get help from CMS' provider ombudsman for the new Medicare card, Dr. Eugene Freund, who will send you information about the new Medicare cards and work inside CMS to settle any implementation problems.

Reminder: new ambulatory surgical grouper policy for commercial plans went into effect April 1, 2018

Ambulatory surgical groupers will be paid as surgical when billed with revenue codes 360 or 490. If surgical services are billed with revenue codes other than 360 or 490, and the claim also includes charges for anesthesia **and** recovery, then the claim will be mapped as surgical and priced according to surgical contracted rates, unless otherwise negotiated.

The 2018 ConnectiCare Surgical Groupers list is not a guarantee of payment for a member's treatment. Our claims edits and payment policies, including your group agreement terms and conditions with ConnectiCare, may affect our payment liability and a member's cost-sharing obligations.

Mapping and assignment updates are effective for all providers as of April 1, 2018, except for new 2018 codes, which are effective Jan. 1, 2018.

For contracts that renewed between Feb. 1 and April 1, 2018, the new policy will go into effect after the next renewal of the contracts. Before then, surgical codes assigned group 0 for 2018 will map to contracted group 1 rates until contract is re-negotiated to include a 0-9 rate structure.

Please note, this updated 2018 ConnectiCare Surgical Groupers list includes code 27096 (inject sacroiliac joint) under grouper 1. An earlier list released in January incorrectly noted that the code was being deleted.

Claims edits that go into effect June 26, 2018

The following claims edits will go into effect June 26, 2018:

Policy	Description	What plans are affected?
Care management services	Care management CPT codes 99487, 99489-99490 are payable only when billed with a primary and a secondary diagnosis. *Reference: AMA CPT code full descriptions*	Commercial and Medicare Advantage
Routine foot care frequency	Routine Foot Care CPT codes 11055-11057, 11719-11721 or G0127 will not be payable if billed more than once within a two-month period. *Reference: NGS Medicare LCD L33636*	Commercial and Medicare Advantage
Corneal pachymetry	CPT 76514 (Ophthalmic ultrasound, diagnostic; corneal pachymetry) will not be payable when billed more than once in a patient's lifetime with a diagnosis of glaucoma or ocular hypertension (OHT). *Reference: NGS Medicare LCD L33630*	Medicare Advantage only

Critical follow-up care for children newly prescribed ADHD medication

Medications can control symptoms of ADHD — which affects nearly 10 percent of American children — but the effectiveness of the drugs depends on close monitoring of patients by their doctors, according to the National Committee for

Quality Assurance (NCQA).

Attention deficit hyperactivity disorder (ADHD) is a HEDIS* measurement for children, ages 6 to 12 years old, who have a new prescription for an ADHD medication. The measurement requires physicians who prescribe ADHD medication to have a follow-up visit with children within 30 days of the initial prescription and two follow-up visits within the nine months thereafter.

Here is more information to help you and the parents and guardians of young patients:

- Provider overview with details on the ADHD measure
- Parent/guardian follow-up visit questionnaire

Also, here are **best practices for meeting the HEDIS measurement for ADHD:**

- At the initial visit, give the parent this follow-up visit questionnaire and ask him or her to fill it out and bring it back to each follow-up visit to help track the patient's progress.
- Schedule all follow-up visits before the patient leaves the office.
- The first follow-up visit should be scheduled for three weeks after the initial prescription is written.
- Subsequent follow-up visits should be scheduled at a minimum of every six weeks after the initial follow-up until the patient's condition has been stabilized by the medication. Once the patient is stable, three-month follow-up appointments are recommended.

**The Health Care Effectiveness Data and Information Set (HEDIS), the quality measurement tool for the NCQA*

Reminder, Tanzeum will no longer be available later this year

The manufacturer of Tanzeum plans to stop making the drug after July 2018. If you have patients who are now taking this drug to treat their diabetes, please make sure to give them new prescriptions.

Below is a list of our preferred Glucagon-Like Peptide-1 Receptor Agonist (GLP-1) products for your patients with commercial group and individual plans, including those sold through Access Health CT, the state insurance exchange.

Please note, non-preferred GLP-1 products will require preauthorization for all of your ConnectiCare patients.

Preferred products	Non-preferred products
Byetta	Adlyxin
Bydureon	Trulicity
Ozempic	
Victoza	

New fax number for all urgent/emergent admission requests

All urgent/emergent authorization requests for hospital admissions must be faxed to:

1-860-674-5727

Use this fax number for members of **both ConnectiCare commercial and Medicare Advantage plans.** Please update your information and forward to all affected departments.

Recent provider headlines

Check out the latest Provider News & Headlines:

- What you need to know: Medicare annual wellness visits and preventive physical exams
- New Medicare Diabetes Prevention Program goes into effect April 1
- Has any of your information changed? Let us know.

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