ConnectiCare

February 2018 – In this issue

It’s not too late: make sure your patients have gotten flu shots

You know the toll the flu is taking on Connecticut. And the season hasn’t peaked yet. Don’t stand by: reach out to patients to make sure they’ve gotten their flu

shots.

Help get more people screened for colon cancer

Help us recognize Colon Cancer Awareness Month in March by getting more of your patients screened. For those who refuse colonoscopies, ConnectiCare now covers Cologuard, a non-invasive alternative for individuals who are not at high risk for colorectal cancer.

Patients listen to their doctors, when it comes to colorectal cancer screening, according to the American Cancer Society. More people get screened when their doctors recommend it.

Here's what you can do:

- Use the "Gaps in Care" reports we send you to follow up with your ConnectiCare patients who have not had the screening done yet.
- Talk to your patients about why they have not had the screening and address their concerns.
- If your patients refuse to have a colonoscopy, there are numerous other screening options that are covered. Use this reference sheet with your patients to review their options.

If you want additional resources to help get more of your patients screened for colon cancer, check out the American Cancer Society's ColonMD: Clinicians' Information Source for free materials you can download and use.

Remember: annual screenings after the age of 50 are covered 100 percent by health plans as a preventive service.

New reimbursement policy for unlisted CPT code 32999

We are implementing a new reimbursement policy for the CPT code for "unlisted procedure, lungs and pleura" that will go into effect April 21, 2018.

The new policy applies to our commercial plans, including employer-sponsored, self-funded and individual plans. We already have a similar policy in place for our Medicare Advantage plans.

Here are the details of the new policy:

- **Policy statement:** CPT code 32999 "Unlisted procedure, lungs and pleura" will always require clinical documentation to determine if the procedure is payable.

  If the service was related to insertion of a catheter or creation of a pocket for post-operative pain management, the service will be bundled to the primary procedure.

  Any other services will be considered on a case-by-case basis.

- **Billing instructions:** Submit clinical documentation describing the procedure.

- **Reimbursement information:** Unlisted code reimbursement for 32999, when payable, is at 65 percent of charges or equal to a comparable procedure with a listed CPT code, whichever is less. Excessive charges will be considered on an individual basis.

A reminder about observation treatment of our Medicare Advantage members

Hospital providers must provide written and verbal notice to Medicare Advantage members when they are receiving observation services as outpatients for more than 24 hours.

This notice is called the Medicare Outpatient Observation Notice (MOON). It

informs Medicare beneficiaries (including Medicare Advantage plan members) that they are receiving outpatient observation services and are not admitted as inpatient of a hospital or critical access hospital (CAH).

All hospitals and CAHs have been required to provide this notice since March 2017. For more information, visit the Centers for Medicare & Medicaid Services (CMS) website.

Policy on "FY" modifier payment reduction updated

We have updated our policy for the new "FY" modifier payment reduction for claims related to X-ray services taken using computed radiography technology/cassette-based imaging. This policy will only affect our Medicare plans effective Jan. 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) requires hospitals and suppliers to use the new modifier "FY" reduction for claims related to X-ray services using computed radiography technology/cassette-based imaging. This affects any radiology codes and reduces by 7 percent the allowable technical component fee or technical component of the global fee starting Jan. 1, 2018. The modifier will further reduce the allowable fee by 10 percent after Jan. 1, 2023.

This reduction will only apply to Medicare claims. We will not apply it to our commercial claims as we previously noted in January. For more information about this modifier reduction, refer to the CMS' guidance.

CMS to mail new Medicare cards starting April 2018

The Centers for Medicare & Medicaid Services (CMS) will start mailing new Medicare cards to beneficiaries in April 2018. This is part of an effort to comply with a law that requires CMS to remove Social Security numbers (SSNs) from all Medicare cards by April 2019.

Please note: 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.

The reissued 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 MBI should be treated like personal health information. To find out what the new Medicare cards mean for providers, check out this resource from CMS.

Medicare preauthorization form for Part B drug benefit now available

We have updated the preauthorization request form for Medicare Advantage Part B covered drugs that require prior approval. Using this form will help make sure we get all the information needed for a timely review of your request. Visit our Medicare provider manual to find out when and for what drugs you should use this form for.

Bone density screening no longer requires preauthorization

You no longer need to seek preauthorization approval before administering bone mineral density (BMD) screenings to your ConnectiCare commercial and Medicare Advantage patients.

As a reminder, all women over the age of 65 should have a bone mineral density test every two years to help prevent or treat osteoporosis.

Recent provider headlines

Check out the latest Provider News & Headlines:

- Coding updates, effective Jan. 1, 2018
- New ambulatory surgical grouper policy, effective April 1, 2018

- Remember to check (or give) referrals for patients with Passage plans
- Make sure our provider directory is current
- Annual HEDIS data collection to start in February
- ALL Medicare providers: federal law prohibits balance billing of dual-eligible patients
- Provider tip: use Magellan Rx website to submit preauth requests for IVIG, SCIG and Remicade products
- Connecticut Vaccine Program: expansion of human papillomavirus vaccine (HPV)

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