ConnectiCare

January 2018 - In this issue

New ambulatory surgical grouper policy, effective April 1, 2018

Ambulatory surgical groupers will be paid according to surgical contracted rates when billed with revenue codes 360, 361, 369, 481, 490, 499 and 750. In addition, claims will be paid according to surgical contracted rates if a service in the ConnectiCare grouper list is billed with a revenue code other than those previously defined and the claim contains charges for anesthesia and recovery room.

Mapping and updated code assignments will be effective April 1, 2018 for all contracted facilities, with the exception of 2018 new codes, which are effective Jan. 1, 2018.

For contracts renewing on or before April 1, 2018, new groupers will take effect upon renewal or as otherwise negotiated.

For contracts renewing after April 1, 2018, prior to renewal, surgical codes assigned group 0 will map to contracted group 1 rates until the contract is re-negotiated to include a 0-9 group rate structure.

Here's the 2018 ConnectiCare Surgical Groupers list.

Remember to check (or give) referrals for patients with Passage plans

Our "Passage" referral plans have more commercial and Medicare Advantage members and more PCPs accepting the plans. If you're a specialist, make sure to check our website, connecticare.com/providers, to see if your Passage patients have valid specialist referrals prior to their appointments.

If you're a Passage PCP, make sure your patients with Passage plans have the referrals they need to get specialist care.

You won't need referrals for the following:

- Ob/gyns
- Endocrinologists

- Lab work
- Preventive services
- Behavioral health
- Services at hospitals, radiology centers, urgent care or walk-in centers, ambulatory surgical centers and other facilities
- Physical or occupational therapy

For more information about Passage, please refer to the articles from the:

- November 2017 *Office Visit*
- December 2017 *Office Visit*

Download FAQs on Passage

ALL Medicare providers: federal law prohibits balance billing of dual-eligible patients

This is a reminder to our Medicare Advantage providers about the proper treatment and billing of patients who are eligible for both Medicare and Medicaid and designated as Qualified Medicare Beneficiaries (QMBs):

- **Our contracts require** all our Medicare providers to see all our Medicare Advantage members, including those who are eligible for both Medicare and Medicaid (often called "dual eligible").
- **The Centers for Medicare & Medicaid Services (CMS) forbids** Medicare providers from discriminating against patients based on "source of payment," which means providers cannot refuse to serve members because they receive assistance with Medicare cost-sharing from a State Medicaid program.

- **Federal law prohibits** balance billing of these QMBs or dual eligible patients for any Medicare cost-share, including deductibles, coinsurance and copayments.

This applies to all Medicare providers, regardless of whether they accept Medicaid.

The QMB program is a Medicaid program that exempts Medicare beneficiaries from having to pay their Medicare cost-shares. If providers want to get paid a patient's cost-share, the bill of service may be submitted to Medicaid for reimbursement.

For more information, check out this Medicare Learning Network resource.

Annual HEDIS data collection to start in February

Our annual HEDIS medical record review begins next month. HEDIS, which stands for Healthcare Effectiveness Data Information Set, is a nationally recognized tool that allows health plans, like ConnectiCare, to measure performance of the services and care our members receive.

We use the results from the HEDIS annual review to improve the quality of members' care and strengthen our educational programs for providers and members.

As part of the review, one or more of your patients may be randomly selected. If this is the case, we may ask your office to provide the patients' medical records through:

- a scheduled visit to your office
- a faxed request
- access to the patient's electronic medical record (EMR)

- an electronic exchange of information via a secure file transfer (FTP) site

Please note, under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted and the release of this information requires no special patient consent or authorization. Please be assured members' personal health information is maintained in accordance with all federal and state laws. Data is reported collectively without individual identifiers.

We appreciate your cooperation and your timely response to our requests. We will do what we can to work quickly and efficiently with you and your office staff to get the information needed.

Make sure our provider directory is current

It's the start of a new year, a good time to check our provider directory to make sure we have the right information for you and your practice.

The provider directory is an essential source of information for our members, who rely on it to find doctors quickly and easily.

Relevant changes include your:

- Tax ID number
- National Provider Identification (NPI)
- Address
- Phone number
- Office hours
- Ability to accept new patients

If anything has changed, let us know by submitting a provider information update form.

Coding updates, effective Jan. 1, 2018

We will follow new policies of the Centers for Medicare & Medicaid Services (CMS) on the modifier "FY" reduction and changes to Medicare coding for mammography:

- Starting Jan. 1, 2018, CMS requires hospitals and supplies to use the **new modifier "FY" reduction** for claims related to X-ray services taken 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 then further reduce the allowable fee by 10 percent after Jan. 1, 2023.

  This reduction applies to Medicare and commercial claims, including claims for patients with plans bought through Access Health CT, the state health insurance exchange.

  For more information about this modifier reduction, refer to the CMS' guidance.

- Under the **2018 Medicare coding for mammography**, CMS has deemed HCPCS codes G0202, G0204 and G0206 obsolete for dates of service after Dec. 31, 2017. For dates of service beginning Jan. 1, 2018, CPT codes 77065, 77066 and 77067 are payable. As a reference, here's the following crosswalk for these CPT codes:
    - G0206 to 77065
    - G0204 to 77066
    - G0202 to 77067

Connecticut Vaccine Program: expansion of human papillomavirus vaccine (HPV)

Providers in most cases are now required to order human papillomavirus vaccine (HPV) for all patients, age 11 and 12, including those with private insurance, through the state Department of Public Health's (DPH) Connecticut Vaccine Program. Please remember, providers cannot sell or receive payment for any vaccine obtained through DPH's vaccine program, but they can bill or charge for administering the vaccine. For more details on the vaccine program, go here.

Provider tip: use Magellan Rx website to submit preauth requests 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 for both our commercial and Medicare Advantage plans:

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

To help you submit preauthorization requests, Magellan Rx's secure website at ih.MagellanRx.com (registration and log in required) is available 24 hours a day, seven days a week. The website will guide you through submitting the information needed for the review. Here are highlights of other features available through the Magellan Rx website.

Recent provider headlines

Check out the latest Provider News & Headlines:

- Magellan Rx to manage preauthorization review for IVIG, SCIG, Remicade and Remicade biosimilar products
- Part B drug benefit for Medicare Advantage members will require preauthorization in 2018
- 2018 formulary changes for our Medicare Advantage plans
- Medical criteria for Dexilant will change Jan. 1; new preauthorization requests required
- Updated ID cards for your patients with plans bought through Access Health CT
- New 2018 codes
- Claims edits that go into effect Feb. 27, 2018
- ConnectiCare voted as "Best Health Insurance Provider" in the Hartford region

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