ConnectiCare


**May 2018 – In this issue**



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## Passage plan referral updates

We have updated our provider website to make it easier to find the specialties that require referrals from Passage primary care providers (PCPs). The improvements include tool tips for setting referral start and end dates for

commercial and Medicare Advantage patients with Passage plans.

With the new tool-tip reminders, Passage PCP providers will be able to enter referrals:

- With a start date of today or a date within the past 90 days, and
- An end date that is within 12 months of the start date.

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## More HCPCS, CPT codes will be needed for certain outpatient commercial claims, starting July 1

We will require HCPCS (Health Care Procedure Coding System) or CPT (Current Procedural Terminology) codes for outpatient UB04 claims billed under three additional revenue codes beginning July 1.

The additional codes are:

- 720 – labor and delivery
- 729 – labor and delivery other
- 769 – treatment room other

The National Uniform Billing Committee 2010 Manual allows for this requirement. This will only apply to our commercial plans.

Here's a full listing of revenue codes which require a HCPCS or CPT code. We will add this document to our online commercial provider manual around July 1.

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## Xarelto will be a preferred drug on Medicare Advantage formulary

Xarelto® will be listed as a preferred drug under our Medicare Advantage formulary for the treatment and prevention of blood clots, effective June 1.

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## Our case management team is available to help you care for your patients

Providers like you can refer ConnectiCare patients to our case management team for help to manage their conditions. Simply call us at 1-800-829-0696.

Our case managers work to help members get healthier and improve their daily-living skills. We do this by working with providers and our members to:

- Improve access to care, so members with complex health conditions get the right services for their conditions
- Support members in scheduling follow-up hospital and doctor appointments
- Coordinate medical care and community services for members who get a lot of services or see many doctors for their conditions.

We will call members to find out their conditions. Then we find benefits and resources available to them and come up with comprehensive care management plans.

Our care management team includes:

- *Registered nurses,* who make initial calls to the members and develop plans based on their goals and needs.
- *Field care managers,* nurses who visit members in their homes or convenient locations to talk about their medications and their conditions. This nurse visit doesn't cost members anything. It's an included benefit under their plans.

- *Social workers,* who work to get available state, local or community resources that can help members. This can include behavioral health referrals.
- *Navigators,* who support the case managers with specific tasks.

**Here's an example of how our case managers have helped**
A member went to the emergency room four times in a span of four weeks. She had a sore throat and it felt like something was stuck in her throat. It turned out the condition was minor. She could have gone to a walk-in center or her primary care provider (PCP) for treatment.

The member didn't know the difference between a walk-in center and emergency room. After she was referred to us, we explained to her the differences of services and costs. We told her that under her plan:

- An emergency room would cost $200
- A walk-in center visit would cost $75
- A PCP visit would cost $40

We gave her information about Spanish-speaking doctors and bilingual walk-in centers near her.

Our case manager also worked with her doctor and pharmacy to make sure the member was taking the right cholesterol-lowering drug. The member was taking two cholesterol-lowering medications a day, which was unusual. Our case manager called the doctor and found the member should only be taking one medication a day.

## Updated in-office laboratory and radiology procedures document

We have updated our in-office laboratory and radiology procedures documents so they are easier for you and your offices to print and keep as handy references. As part of the update, we removed the advanced radiology procedures from the

documents. Those procedures will follow our existing preauthorization guidelines as noted in our commercial and Medicare provider manuals.

Reimbursements for procedures included in the in-office laboratory and radiology documents will not change. We want to provide you a resource that clarified what we are already doing and improve the payment processing of your claims.

Here are the documents:

- In-Office Laboratory & Non-Advanced Radiology Procedures (Commercial)
- In-Office Laboratory & Non-Advanced Radiology Procedures (Medicare)

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## Has any of your information changed? Let us know.

Check our provider directory to make sure we have the right information for you and your practice. Our members rely on our provider directory to find doctors like you quickly and easily.

Relevant changes include your:

- tax ID number
- national provider identification (NPI)
- address
- phone number
- office hours
- ability to accept new patients

Submit any changes by filling out our provider information update form and sending it back to us as noted on the form.

### Recent provider headlines

Check out the latest Provider News & Headlines:

- Passage PCPs and specialists: download this list of specialties that need referrals
- Notice of Medicare Non-Coverage requirements: SNFs and home health providers
- New Medicare cards rolling out
- Reminder: new ambulatory surgical grouper policy for commercial plans went into effect April 1, 2018
- Claims edits that go into effect June 26, 2018
- Critical follow-up care for children newly prescribed ADHD medication
- Reminder, Tanzeum will no longer be available later this year
- New fax number for all urgent/emergent admission requests

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