ConnectiCare

September 2018 – In this issue

determinations

Has any of your information changed? Let us know.

Information you need for the 2018-2019 flu season

ConnectiCare members are covered for the flu vaccine. For most members, there is no copayment, coinsurance or deductible if the only reason for a visit is to get a flu shot. If there is an additional, separate reason billed for a visit, applicable copayment, coinsurance and deductible will apply.

MEDICARE CODES FOR FLU VACCINATIONS	
90653	90685
90656	90686
90662	90687
90672	90688
90674	90756
90682	Q2035
Administration Code: G0008	

COMMERCIAL CODES FOR FLU VACCINATIONS	
90653	90674
90656	90682
90658	90685
90662	90686
90672	90687
90756	90688
Administration Codes: 90460, 90461, 90471, 90472, 90473, 90474	

If a member receives a flu vaccination from a non-participating provider, we cover the usual-and-customary amount. If a member pays out of pocket, he or she can provide a receipt to ConnectiCare along with a completed Out-of-Plan Reimbursement Form. Medicare members should use this Medicare Out-of-Plan Reimbursement Form.

Members may call us at 1-800-251-7722 (commercial plans) or 1-800-224-2273

(Medicare plans) to request a reimbursement form. TTY service is also available at 1-800-833-8134 (commercial plans) or 1-800-842-9710 (Medicare Plans).

Use the right sleep study codes for payment

A reminder that the following three sleep study procedures require exact codes be billed for payments to be authorized.

Service	CPT code to be used	Notes
Polysomnography sleep staging with 4 or more additional parameters of sleep for ages less than 6 years old	95782	Payment allowed only if the authorization of this CPT code matches exactly on the claim.
Polysomnography with CPAP (Continuous positive airway pressure) with 4 or more additional parameters of sleep for ages less than 6 years old	95783	Payment allowed only if the authorization of this CPT code matches exactly on the claim.
Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	95807	Payment allowed only if the authorization of this CPT code matches exactly on the claim. This service must be conducted in a sleep lab.

And – codes for all durable medical equipment for treatment of sleep apnea must also be exact.

Anticipate prescription drug questions from Medicare members

ConnectiCare will soon notify members in our Medicare Advantage plans of changes to their prescription formularies for 2019. Please support your patients who may be affected by:

- Anticipating any changes in medications that may be needed,
- Answering your patients' questions, and
- Writing new prescription orders for them, when needed, well before the New Year.

American Healthcare Leader features Rob Kosior, ConnectiCare's chief operating officer

American Healthcare Leader recently featured Robert Kosior, ConnectiCare chief operating officer, who oversees clinical, quality and network teams. Check out what he has to say about our community of care and how we are tailoring plans and services to the local market.

Claims edits that go into effect Nov. 27, 2018

Please refer to the table below for claims edits that will go into effect on Nov. 27, 2018:

Policy	Description	Affected plans
Low dose CT scan for lung cancer screening	We will deny G0297 (Low dose CT scan (LDCT) for lung cancer screening) when billed by any provider more frequently than once per year. *Guidance: Centers for Medicare & Medicaid Services*	Medicare only

Valstar® code J9357	Valrubicin (intravesical) should be reported with an appropriate bladder instillation procedure code CPT 50391 or 51720. *Guidance: FDA–approved package insert in prescribing information and the pharmaceutical compendium.*	Commercial and Medicare
Iluvien® code J7313	When fluocinolone acetonide intravitreal implant (J7313) is injected into the eye (vitreous), it should be reported on the same claim with the appropriate injection procedure code CPT 67028. *Guidance: Drug Manufacturer*	Commercial and Medicare

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Update on UConn study on 3Ds

The University of Connecticut Center on Aging and the School of Medicine at UConn Health are recruiting ConnectiCare Medicare Advantage members who may have one or more of the "3Ds:" dementia, depression and delirium.

Primary care providers (PCPs) may receive a letter from UConn letting them know their patient is involved in the ongoing study. The letter may also include treatment recommendations for the patient.

The study, funded by the national Patient-Centered Outcomes Research Institute, will test how a new home-based clinical team care model may improve health-related outcomes of older adults living with cognitive vulnerability and their families.

The study is recruiting 760 adults in Connecticut who are age 65 and older, living at home in Connecticut for the next 12 months and have their Medicare insurance through ConnectiCare, a partner in the study. Family members of these adults will

also be invited to participate.

Recruitment will be based on any claims providers have submitted in the prior month. If the claims contained any ICD-10 codes related to dementia, depression or delirium, a ConnectiCare representative will call the member or family member (for adults diagnosed with dementia) to find out if they are interested in participating in the study and if UConn can contact them.

The study is not taking doctor referrals at this time. If a doctor wants his/her patients to be considered for the study, make sure to include ICD-10 codes related to dementia, depression or delirium on any claims related to the treatment of that patient.

Gonal-F is preferred infertility hormone treatment

Gonal-F is the preferred follitropin infertility treatment for all ConnectiCare commercial members starting Oct. 1, 2018. Gonal-F will be moved to a preferred brand tier in our formulary.

You'll need to continue to obtain preauthorization after Oct. 1, 2018, for all infertility treatments. This applies to all ConnectiCare commercial members with Connecticut plans.

Please note, this change affects only new cycles after Oct. 1, 2018. Unexpired preauthorization approvals remain valid.

A reminder about advising patients on Medicare plan enrollment

The Centers for Medicare & Medicaid Services (CMS) reminds providers that they should remain neutral when discussing Medicare and Part D plans with their patients. The Medicare annual enrollment period (AEP) for 2019 starts Oct. 15, 2018, and ends Dec. 7, 2018.

Providers may:

- Provide the names of plans or plan sponsors with which they may contract and/or participate
- Answer questions or discussing the merits of a plan or plans, including cost sharing and benefit information
- Provide information on and help applying for the low-income subsidy (LIS)
- Refer patients to plan marketing materials that are available in common areas
- Refer their patients to other sources of information, such as state health insurance assistance programs (SHIPs), plan marketing representatives, state Medicaid offices, local Social Security offices or CMS, either through its website or 1-800-MEDICARE.
- Share information with patients from the CMS website, including the "Medicare and You" handbook or "Medicare Plan Finder" or other resources written or approved by CMS

Providers should not:

- Offer scope-of-appointment forms for plan sponsors
- Accept Medicare enrollment applications
- Mail marketing materials on behalf of plans
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
- Offer anything of value to induce plan enrollees to select them as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from a plan for beneficiary enrollment activities
- Distribute materials or applications within an exam-room setting

Providers who violate these regulations could face penalties up to and including termination of contracts with Medicare and Part D plans and plan sponsors.

If you have questions on discussing Medicare enrollment with your patients, please contact your network account manager.

In-office laboratory reimbursement policies updated

We have removed all non-advanced radiology procedures from our in-office laboratory reimbursement policy because we're no longer limiting providers from performing these radiology procedures in their offices. We will reimburse providers for these services based on our contracted rates. All existing in-office laboratory procedures that we cover remain the same.

The updated in-office laboratory policies below go into effect Nov. 1, 2018:

- Overview of Coverage Approved In-Office Laboratory Procedures (Commercial)
- Overview of Coverage Approved In-Office Laboratory Procedures (Medicare)

Stay in-network when referring patients to skilled nursing facilities or home health care services

Providers should only refer ConnectiCare members to skilled nursing facilities or home health care services that are in-network for the members' plans. Help save your patients from any costly out-of-network charges: check our provider directory to make sure you send your patients to the providers covered under their plans.

A reminder about 'turnaround' times for non-urgent pre-service organization determinations

We've gotten some questions about the timing of decisions on standard (non-urgent) pre-service organization determinations. Under the regulations, we have:

- **Fourteen (14) calendar days** from receipt of requests for your patients with Medicare Advantage plans
- **Fifteen (15) business days** from receipt of requests for your patients with commercial plans

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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.

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