ConnectiCare

December 2019 - In this issue

Provider resource: 2020 changes to Medicare Advantage plans

Download this guide to changes in our 2020 ConnectiCare Medicare Advantage plans that affect you and your patients. Please share it with your staff. The guide

includes:

- Sample images of 2020 member ID cards for new ConnectiCare Medicare Advantage members and EmblemHealth Medicare Advantage members.
- Instructions on how to submit claims for dates of services that cross over from 2019 into 2020.
- Information on how to sign up for electronic funds transfer through PNC Remittance Advantage.

Last month's *Office Visit* included details about 2020 changes, too.

Dual special needs plan member information available through provider website

After Jan. 1, 2020, ConnectiCare providers can use connecticare.com/providers to check eligibility, benefits and claims information for 2020 dates of service for Medicare Advantage members with a Dual Special Needs Plan (HMO D-SNP).

New 2020 codes

Billing codes are updated each year by the American Medical Association. Please refer to the 2020 manuals for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS).

We're now updating our systems for new 2020 codes. Claims submitted with new codes for covered services will be noted on the explanation of payment (EOP) statements with an explanation code of Z0 that states "New code, rate not yet established, will be adjudicated by March 31, 2020." This applies to commercial claims.

We will automatically adjust commercial claims submitted with old codes between Jan. 1, 2020 and March 31, 2020 to new, covered codes. Providers do not need to resubmit claims. When adjustments are made and claims paid, EOPs will inform providers that the payment includes adjustment of the new codes that paid $0 upon initial submission.

Medicare claims containing a new code will be paid when the new 2020 codes are

configured. We will also automatically adjust Medicare claims submitted between January and the date when the 2020 codes have been configured with new, covered codes. Medicare providers do not need to resubmit claims. When adjustments are made and claims paid, EOPs will inform providers that the payment includes adjustment of the new codes.

Reminders about caring for our Medicare Advantage members

Please keep the following in mind as you provide care and services to our Medicare Advantage members:

- **Follow the Medicare Outpatient Observation Notice (MOON) requirements.**

  Hospital providers must give 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.

- **Do not bill patients who are designated as Qualified Medicare Beneficiaries (QMBs).**

  Federal law prohibits all Original Medicare and Medicare Advantage providers and suppliers from billing individuals enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Part A and Part B cost-sharing under any circumstances. Providers who inappropriately bill individuals enrolled in QMB are violating their Medicare Provider Agreement and may be subject to sanctions.

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.

Also, as a reminder:

- **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." That means providers cannot refuse to serve members because they receive assistance with Medicare cost-sharing from a state Medicaid program.

Medical policies updated for 2020

We have updated the following medical policies for 2020. Please refer to the policies for details:

- Medical Policy: Bariatric Surgery (Commercial), effective Jan. 1, 2020.
- Medical Policy: Cardiac Event Monitors (Commercial), effective Jan. 1, 2020.
- Medical Policy: Chemical Peels (Commercial), effective Jan. 1, 2020.
- Medical Policy: Gender Affirming/Reassignment Surgery-Connecticut (Commercial), effective Jan. 1, 2020.

All these policies will be available on our provider website before the end of the year.

Changes to claims payment for Medicare Advantage inpatient stays

Starting Jan. 1, 2020, ConnectiCare will only process the inlier payment of an inpatient stay for our Medicare Advantage claims. The outlier portion of the claim will be denied until we receive an itemized bill from the provider. Payment for the applicable outlier amount will be released after ConnectiCare reviews the itemized bill. This process will only apply to claims that meet the applicable dollar threshold that triggers the review.

Update on Medicare Beneficiary Identifiers (MBIs)

If you are treating patients with original Medicare, your practice and your vendors should be using the new Medicare Beneficiary Identifiers (MBIs) for those patients. Starting Jan. 1, 2020, providers must only use MBIs on claims submitted to Medicare (with a few exceptions).

The Centers for Medicare & Medicaid Services (CMS) has completed mailing new Medicare cards to Medicare beneficiaries. The cards have new MBIs replacing the old Health Insurance Claim Numbers (HICNs) that were based on beneficiaries' Social Security numbers. **These Medicare cards and MBIs do not apply to Medicare Advantage plans, like the ones ConnectiCare offers.**

MBIs should be treated as personal health information. To find out more about MBIs and what they mean for providers and office managers, check out this CMS resource.

Provider service hours during the holidays

Our regular provider service hours are 8 a.m. to 6 p.m. Monday through Friday. This holiday season we are closing on the following days:

- Wednesday, Dec. 25: closed
- Wednesday, Jan. 1: closed

Recent provider headlines

Check out the latest Provider News & Headlines:

- 2020 updates to Medicare Advantage plans
- Preauthorization updates for 2020
- Medical policies updated for 2020
- Reducing the risk of falls: prevention begins with you
- ConnectiCare care management team to manage kidney care program, starting January
- Members may be calling you to close gaps in care
- Medical record reviews start this month
- Has any of your information changed? Let us know.
- ConnectiCare in the community

Keep in touch