ConnectiCare
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August 2020 - In this issue

[ConnectiCare centers reopen in four communities](#)

[Recent provider headlines](#)

Cost shares for PCP and mental health clinician visits waived for Medicare Advantage members

ConnectiCare Medicare Advantage members can visit in-network primary care providers (PCPs) and in-network behavioral health clinicians for covered services **in person or by telehealth** from Aug. 1 through Dec. 31, 2020 without paying cost shares.* Copayments, deductibles, and coinsurance costs — listed in a member's 2020 Evidence of Coverage — will be waived through the end of 2020.

This does not apply to Medicare members with ConnectiCare Choice Dual (HMO D-SNP). Medicaid covers these cost shares.

Cost-share waivers are part of ConnectiCare's response to the coronavirus (COVID-19) pandemic. We want to help our Medicare Advantage members stay healthy and safe and encourage them to see their primary care doctors for needed preventive care, medication management, screenings and immunizations, including the flu shot.

We also want members to be able to seek the care of mental health clinicians during the public health crisis. This policy does not cover behavioral treatment at a facility-based inpatient setting or partial hospitalization services.

Medical specialist care
Please note: this temporary policy does not apply to medical specialist care. Medicare Advantage members can continue telehealth visits with medical specialists for covered services without a cost share through Sept. 9, 2020. After that date, members will be responsible for cost shares for medical specialist visits that take place in person or by telehealth.*

Other COVID-19 news

- **COVID testing coverage**: Visits, including telehealth visits, by Medicare Advantage members for a COVID-19 test continue to have no cost share for both in-network and out-of-network providers through the declared national public health emergency. Members also have no cost share for the lab test during the public health emergency. Refer to Payment Policy: COVID-19 Billing Guidelines (Commercial/Medicare Advantage) for more information.

- **Teladoc® telemedicine visits**: Members whose plan benefits include Teladoc will also have no cost share for those services through Dec. 31, 2020.
- **Passage PCP referrals**: Our commercial members with Passage plans will need Passage PCP referrals to seek specialist care after Sept. 9, 2020.

**This assumes the Centers for Medicare & Medicaid Services will continue to allow health plans to adjust benefits mid-year during the public health emergency. As a result, the end date of the waiver is subject to change*.

Extension of Temporary Payment Policy: Supplemental Telehealth Guidelines — Commercial/Medicare Advantage

Recognizing the ongoing and critical need to limit the spread of the coronavirus (COVID-19), we will again extend our temporary program of reimbursing in-network providers for telehealth visits through March 15, 2021.

This policy is intended to reflect the requirements of applicable federal, state and agency laws, regulations and directives ("Applicable Law") and will remain in effect for the period required by Applicable Law. ConnectiCare reserves the right to amend and/or revoke this policy at any time to the extent such amendment or revocation reflects any changes in Applicable Law.

Please refer to these documents for details:

- Temporary Payment Policy: Supplemental Telehealth Guidelines — Commercial/Medicare Advantage
- Telehealth/Telemedicine and Telephone Call Frequently Asked Questions

The policy applies to members of all ConnectiCare commercial and Medicare Advantage plans.

New Compass plans available on Jan. 1, 2021 and later

ConnectiCare plans to offer commercial group and individual customers a new line of health plans with preferred primary care providers (PCPs) and hospitals. The new **Compass plans**, available for start dates of Jan. 1, 2021 and later, are one of the ways we are working to help employers and individuals under age 65 manage their out-of-pocket costs.

Compass plan members who visit "preferred" primary care providers (PCPs) and hospitals will have lower cost shares — copays, coinsurance and/or deductibles — as outlined in their plan documents. Providers in the ConnectiCare commercial network will participate in Compass plans and appear in provider directories published for plan members.

Compass plan preferred providers as of Jan. 1, 2021 will be PCPs who participate in commercial Passage plans and selected hospitals from each county in Connecticut. All specialists and ancillary providers will be preferred providers.

It's important to note:

- There will be no differences in reimbursement for preferred and participating providers; all will be reimbursed according to their current ConnectiCare contractual fee schedule.
- All non-preferred PCPs and hospitals will be available to members as participating providers.
- Compass plans will not require PCP referrals to specialists.

More information

Designation of preferred PCPs and hospitals was determined through analysis of cost and objective third-party quality data. For hospitals, cost indices included inpatient and outpatient services and were adjusted for case mix.

Compass preferred-provider designations will be reviewed and revised annually. Compass plans will be available to individuals and families enrolled in ConnectiCare plans sold through Access Health CT and plans available to employer groups. Medicare Advantage plans are not affected.

We created Compass plans in response to market forces. Customers are seeking relief from costs while maintaining quality of care.

New EOP statements to apply to members with new 2020 ID numbers

As part of our partnership with PNC Bank and the ECHO Health payment platform, you will begin to see new explanation of payments (EOP) statements. Here's a document to help you understand the new format. The new EOP statements will apply to members who have new member ID numbers that start with the letter K.

We began using PNC Bank and the new platform to pay Medicare Advantage claims starting July 15, 2020 and began transitioning commercial claims** on Aug. 1, 2020.

New member ID numbers and cards for ConnectiCare members
We have been issuing new member ID numbers and cards for Medicare Advantage members with effective dates of Jan. 1, 2020 and later. Now we are beginning to issue new member ID numbers and cards to commercial members. **We will complete roll-out of the new member ID numbers for all our commercial plans on or about Jan. 1, 2021**.

Make sure to check ID cards and ID numbers for all commercial patients and use the new ID numbers for dates of services on and after Aug. 1, 2020.

There are no changes to the claims submission process. To avoid delays in claims payments, please make sure to use the right member ID number for your claim submissions.

Updates to 2020 provider payments
Here's a quick recap of provider payment changes:

- **More frequent provider payments**: We are moving from once-a-week check runs to a daily schedule for our commercial members with new "K"

ID numbers starting Aug. 1, 2020. We have been paying claims daily for Medicare Advantage members since Jan. 1, 2020.

- **Transition to the PNC Bank and ECHO Health payment platform** to pay Medicare Advantage claims starting July 15, 2020 and commercial claims** starting Aug. 1, 2020. This means providers will need to go to:
  - https://view.echohealthinc.com/EFTERADirect/EmblemHealth/ to sign up for electronic funds transfer (EFT) for EmblemHealth and ConnectiCare payments, or
  - providerpayments.com to view electronic remittance advice (ERA) statements.
- **Virtual card payments** will be issued after July 15 for Medicare claims; Aug. 1 for commercial claims:** If you are not enrolled in EFT through the ECHO website, your office will receive virtual credit card payments. You will get payment notifications by fax or mail, each containing your EOP with a virtual credit card number unique to that ConnectiCare claims payment. Normal transaction fees apply based on your merchant acquirer relationship. If you want to continue receiving virtual card payments, you don't have to do anything. *If you want to get EFT payments instead, go to the ECHO website after receiving a virtual card payment and enroll for EFT*.

***This only applies to commercial claims submitted after Aug. 1, 2020 for commercial members with new ID numbers that start with the letter "K." You will still get check and electronic fund transfer (EFT) payments through Bank of America for claims submitted for commercial members with older ID numbers*.

2020-2021 flu season information

All ConnectiCare members are covered for the flu vaccine. And here are the vaccine codes we cover:

Medicare codes for flu vaccinations		Commercial codes for flu vaccinations	
90653	90686	90653	90686

90662	90687	90662	90687
90672	90688	90672	90688
90674	90694	90674	90694
90682	90756	90682	90756
90685		90685	
Administration code: G0008		Administration code: 90460, 90461, 90471, 90472, 90473, 90474	

For most members, there is no copayment, coinsurance or deductible if the only service that is provided during the visit is the administration of a flu shot. If there is an additional, separate reason billed for a visit, applicable copayment, coinsurance and deductible will apply.

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 us along with a completed Out-of-Plan Reimbursement Form. Medicare members should use this Medicare Out-of-Plan Reimbursement Form.

Express Scripts providing commercial drug utilization management services

This is a reminder that Express Scripts (ESI) is now performing most drug utilization management services for ConnectiCare commercial plan members, including those with plans sold through Access Health CT. This means you must submit requests for preauthorization, quantity limits and step therapy for commercial members to ESI.

This **does not** apply to Medicare pharmacy utilization management requests or adult chemotherapy and supportive agents. Please follow the usual process for chemotherapy and supportive agents as well as Medicare requests.

Electronic prior authorizations

We know you want to focus on your patients, not administrative tasks. That's why we made this change and why we encourage you to take advantage of ESI's Electronic Prior Authorization (ePA) option.

ePA is *fast, secure, and simple*. It's the **fastest way to get your authorizations approved**. You can send 11 requests in the time it takes to fax just one. Any authorized personnel, including nurses and office staff, can use your electronic health record (EHR) or sign in to an online portal. You save time, and patients get their medications faster.

How to submit preauthorization requests with ePA:

- Check with your EHR vendor to ensure you have the latest software version enabling ePA. If not, create a free account online for the tool that works best for your office: **CoverMyMeds, Surescripts, or ExpressPAth®**.
- Once enabled, you will see drugs requiring preauthorization while prescribing.
- When the prescription is submitted, ESI will confirm the need for preauthorization and electronically send clinical questions.
- You can answer the questions or place the request in a queue for office staff to complete later.
- Once complete, ESI will process the request and quickly respond with approval or denial.

Use these phone and fax numbers for preauthorization requests for commercial members.

- Pharmacy drug reviews: call **1-877-417-5383**, 24/7/365 or fax to **1-877-251-5896**
- Medical drug reviews: call **1-877-391-7821**, 8 a.m. to 7 p.m., Monday through Friday or fax to **1-888-631-8817**

Medicare Advantage contact information
There is **no change** in phone or fax numbers for Medicare Advantage preauthorization requests. ConnectiCare will continue utilization management review for Medicare Advantage members. Continue sending preauthorization requests for Medicare Advantage members by phone or fax to:

- Specialty drugs: call **1-888-447-0295**, 8 a.m. to 6 p.m., Monday to Friday or fax to **1-877-243-4812**
- Pharmacy drugs: call **1-877-224-8168**, 8 a.m. to 6 p.m., Monday to Friday or fax to **1-877-300-9695**

As a reminder, New Century Health (NCH) will need to preauthorize all **oncology-related chemotherapeutic drugs** and supportive agents when they're given to commercial and Medicare Advantage patients in the physician's office, outpatient hospital or ambulatory setting.

Please see the preauthorization overview chart for a summary of these requirements.

Health Outcomes Survey and your Medicare Advantage patients

Members of Medicare Advantage plans, including ConnectiCare, are asked to take the Health Outcomes Survey (HOS). The survey is intended to assess plans' ability to maintain or improve members' physical and mental health over time. Your interactions with Medicare Advantage members influence the results.

The survey is administered to a random sample of our Medicare members. This same group of members is surveyed again two years later, asking them to evaluate their own health over a period of time and recall the discussions they have had with their doctors.

Your interactions with patients affect their responses to the HOS questions. Six of the measures covered under the HOS are included in the annual Medicare Star ratings:

- Evaluation of physical health
- Evaluation of mental health

- Bladder control
- Physical activity
- Falls risk
- Bone health in women

For more information about the HOS survey and tips to help improve care, check out pages 58 and 59 in our Quality Measure Resource Guide.

Update on preventive colon cancer screening

Starting Oct. 1, 2020, ConnectiCare will no longer cover the use of barium enemas for preventive screening for colon cancer. This follows the 2018 American Cancer Society recommendation based on clinical evidence, studies, current screening options and colorectal cancer risks.

ConnectiCare covers other recommended options for colon cancer screening. Remember, annual screenings after the age of 50 are covered 100 percent by health plans as a preventive service. Refer to our preventive services list for details and guidelines.

Help us get more of your patients screened. According to the American Cancer Society, patients listen to their doctors when it comes to colorectal cancer screening.

Please note, ConnectiCare may still cover barium enemas for diagnostic purposes.

Reminder: Alternative pain management services are available to our members

The growing misuse and abuse of opioids in Connecticut has become a "public health concern," according to the State Department of Public Health.

We want to remind health care providers that there are alternative treatment options available to help patients manage their pain without the use of prescription drugs and opioids.

Members may have access to both prescription medication and non-prescription medication alternatives which include, but are not limited to:

- Prescription medication alternatives:
  - NSAIDS
  - Topical analgesics
  - Cox-2 inhibitors
  - Skeletal muscle relaxants
  - Anti-depressants
  - Anticonvulsants
  - Cortico-steroids
- Non-prescription medication alternatives:
  - Chiropractic services
  - Physical therapy
  - Occupational therapy
  - Physician medicine/rehabilitation
  - Cognitive behavioral therapy
  - Nutrition counseling
  - Osteopathic manipulation medicine
  - Nerve block treatments
  - Spine surgery
  - TENS (transcutaneous electrical nerve stimulation) unit

Please sign in to our provider website to view benefit information for your patients.

Claims edits that go into effect Nov. 1, 2020

Please refer to the table below for claims edits that will go into effect on Nov. 1, 2020. These edits will apply to both commercial and Medicare Advantage plans.

Rule type	ClaimsXten rule	ClaimsXten rule description
Ambulance rules	AMB_BUNDLED_SVC	• This rule recommends the denial of any claim lines with a procedure code other than a valid ambulance HCPCS service or mileage code reported along with a valid ambulance HCPCS procedure code for the same beneficiary, same date of service, by the same provider and on Same Claim Only.
	AMB_FREQUENCY	• This rule recommends the denial of an ambulance claim line when the frequency exceeds than allowed limits for a valid ambulance HCPCS service code reported for the same member on the same date of service from. • This rule will evaluate unique ambulance trip frequency, based on an Ambulance Transport code submitted on the same DOS, Same Member, Same PROVIDER ID, same Origin/Destination

		MODIFIER and on the same claim ID ONLY.
	AMB_MOD_PROC_VALID	• This rule recommends the denial of ambulance services for the following reasons: o Claim lacks an appropriate origin-destination modifier or modifier QL. o Institutional (facility-based) claim lacks an appropriate arrangement modifier (QM or QN). o Two claim lines for the same date of service lack identical origin-destination and arrangement modifiers.

		For unique Ambulance trip auditing, this will evaluate Ambulance Transport and mileage codes submitted on the Same Claim ID Only and by the same Provider ID, for same member and on same Date of Service.
	VALID_AMB_SVC	- This rule recommends the denial of inappropriate ambulance services for supplier and provider claims, as defined by CMS. Generally, two lines of coding (i.e. mileage code and transport/service code) are required in most ambulance billing scenarios. - This rule also recommends the denial of claim lines, which lack the presence of an ambulance origin-destination modifier and institutional claim lines which lack appropriate arrangement modifiers as required. - For unique Ambulance trip auditing, this will evaluate Ambulance Transport and mileage codes submitted on the Same Claim ID

		Only and by the same Provider ID, for same member and on same Date of Service.
Durable medical equipment rules	DME_OWN_MADV	• Denies a current claim line for a DME item that has been submitted with an ownership modifier, when the same DME item has been previously paid in history with another or the same ownership modifier. • Ownership modifiers are -NU (New), -NR (New when rented), and -UE (Used). They indicate that the DME is paid for in one lump sum (paid for in total, in one payment). • The rule looks for the DME item and the presence of ownership modifiers -NU, -NR, or -UE on the current claim and the support claim line.
	DME_RENT_HX_OWN_MADV	• Denies claim lines submitted for the rental of a DME item when the same DME item is beneficiary owned in history.

		• It is unexpected that a previously owned DME would be rented. A previously submitted paid claim for the same DME indicates that it was beneficiary owned and it is likely that one lump-sum payment or a rental with subsequent purchase has already been made for the DME. • The current claim line looks for the presence of rental modifier -RR. The support claim lines look for the presence of ownership modifiers -NU, -UE, and -NR. • Modifier Descriptions: o RR – Rental o NU – New Equipment (Indicates Ownership) o NR – New when Rented, subsequently purchased (Indicates Ownership) o UE – Used (Indicates Ownership)

	DME_RENT_OWN_MADV	• Denies claim lines submitted for the rental of a DME item in which the rental payment for the DME item exceeds the maximum number of rental payments as defined by CMS. • Each DME item has a number of rental payments permitted as defined by the DME fee schedule payment guidelines. The rule looks for the presence of rental modifier -RR on both the current and support claim lines.
Obstetrical rule	OB_PACKAGE_RULE	• This rule audits potential overpayments for obstetric care. It will evaluate claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery and postpartum services, i.e. 59400, 59510, 59610 and 59618) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or

		delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable) 280 and 322 days respectively.

ConnectiCare president discusses our "Peace of Mind" program and telehealth

As the pandemic continues, we're committed to supporting our members and helping them get the care they need. Our president, Eric Galvin, recently discussed our "Peace of Mind" program and telehealth as some of the ways we're helping our members during this time.

Check out the interview with the *Fairfield County Business Journal*.

ConnectiCare reopen in four communities

Connecticut is reopening – and so are we. We're welcoming members back to our ConnectiCare centers – with some changes. Go to visitconnecticare.com to see our updated hours, locations and the safety guidelines we have implemented. Appointments are required. No drop-ins, please, for everyone's health and safety.

We are now open in **Manchester**, **Norwalk**, **Shelton** and **Waterbury**. A new larger center in Shelton (876 Bridgeport Ave.) replaces the former center in Bridgeport. Our Newington center will not reopen. We look forward to serving members from the Newington area at the Manchester center.

Recent provider headlines

Check out the latest Provider News & Headlines:

- Reminder: Check your patients' member ID cards for new member ID numbers

- Importance of managing your patients’ antidepressant medications

Keep in touch

While we believe the information in this communication is accurate as of the date published, it is subject to correction or change during the rapidly evolving response to the COVID-19 outbreak.