ConnectiCare
an EmblemHealth company

Office Visit
News for health care providers

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Telehealth policy and waiver of Passage PCP referrals extended through Sept. 9, 2020

We will again extend our temporary program of reimbursing in-network providers for telehealth visits through Sept. 9, 2020 in recognition of the ongoing and critical need to limit the spread of the coronavirus (COVID-19).

Do not charge any cost share to our members. We are waiving member cost shares — including copayments, deductibles and coinsurance — that may apply to telehealth visits through Sept. 9. Please refer to this Temporary Payment Policy: Supplemental Telehealth Guidelines — Commercial/Medicare Advantage for details.

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

No referrals for Passage plan members also extended through Sept. 9, 2020
Our commercial members with Passage plans will not need Passage PCP referrals to seek specialist care through Sept. 9, 2020. Our provider website will be updated to reflect this extension.

Please visit the dedicated COVID-19 page on our provider website for the latest ConnectiCare news and information.

Authorization requirements to be restored July 1, 2020

During the peak of the coronavirus (COVID-19) outbreak, we temporarily streamlined authorization processes to help hospitals and health care systems care for our members. As hospitalizations due to COVID-19 continue to drop, we are confident our hospitals and health care systems will be able to care for our

members as they did prior to the peak of the outbreak. As a result, **ConnectiCare will restore most authorization processes starting July 1, 2020**.

We will be returning to the normal process for:

- Preauthorization approval[1]
- Home health care services
- Skilled nursing facilities (SNFs), long-term acute care hospitals (LTACHs) and acute rehabilitation facilities

These updates cover ConnectiCare network providers caring for members of both commercial and Medicare Advantage plans, unless noted otherwise. These do not apply to ConnectiCare plans in Massachusetts. **For members covered by ConnectiCare of Massachusetts, Inc., plans,** we will continue to temporarily suspend preauthorization and concurrent review for inpatient services for Massachusetts hospital admissions through Sept. 30, 2020, in compliance with state requirements.

Extension of previously approved preauthorization requests
Beginning July 1, we will no longer extend previously approved preauthorization requests by 90 days. Approvals that have been extended before July 1 are not affected. This applies to:

- Inpatient elective admission requests
- Outpatient procedures/requests
- Out-of-network requests
- Infertility services (commercial plans only)
- Durable medical equipment

Please note, any service or surgery canceled without a reschedule date or rescheduled outside of the authorized date range will require a new preauthorization from ConnectiCare as of July 1.

You can submit preauthorization requests by:

	Commercial patients	Medicare Advantage patients
Fax:	1-860-674-5893 (preauthorization) 1-860-409-2437 (home care)	1-866-706-6929 (preauthorization) 1-860-678-5291 (home care)
Phone:	1-800-562-6833 extension 8552	1-800-508-6157 extension 8553

Home health care services and requests
Also after July 1, ConnectiCare will review and approve initial and re-authorization requests for home health care services for date spans that meet the need for the services. This applies to the following requests:

- Physical therapy
- Occupational therapy
- Speech therapy
- Medical social worker
- Home health aide
- Skilled nursing visit
- IV therapy

Hospital discharges to SNFs, LTACHs and acute rehabilitation facilities again require preauthorization
Discharges of ConnectiCare members from hospitals to SNFs, LTACHs or acute rehabilitation facilities after July 1 will need preauthorization before the date of discharge. Please submit preauthorization requests to us or our partner, CareCentrix, as noted in the chart below:

Admission to:	ConnectiCare	CareCentrix

LTACHs	1-800-508-6157 (Fax) 1-860-678-5282 (Phone)	N/A
SNFs	N/A	1-844-359-5388 (Fax) 1-866-501-4665 (Phone)
Acute rehabilitation	N/A	1-844-359-5388 (Fax) 1-866-501-4665 (Phone)

As we update our policies and practices in response to the coronavirus (COVID-19) pandemic, we will do our best to keep you informed. Please refer to **connecticare.com/providers** for the latest news and the most up-to-date information.

[1]*Preauthorization approval is not a guarantee of coverage. Coverage is dependent on member eligibility at the time service is rendered and if the member has not exceeded benefit maximums under his/her plan. Any services rendered over the benefit maximums for a member's plan year will fall under the member's financial responsibility.*

What ConnectiCare's Medicare Advantage providers need to know about the CARES Act

ConnectiCare will follow Medicare guidelines in the federal coronavirus (COVID-19) stimulus bill (known as the "CARES Act") to:

- Add 20% to the COVID-19 inpatient reimbursement for both in-network and out-of-network care given to Medicare Advantage members.
- Temporarily suspend the 2% provider payment reduction fee known as "Medicare sequestration" from May 1, 2020 through Dec. 31, 2020.

This only applies to our members with Medicare Advantage plans.

Adding 20% to COVID-19 inpatient reimbursement
In accordance with the Centers for Medicare & Medicaid Services (CMS) methodology, ConnectiCare will add 20% to the MS-DRG-based inpatient

reimbursement (operating component only) for patients who were discharged with a COVID-19 diagnosis after Jan. 27, 2020. ConnectiCare will identify and reprocess any claims that should have included the additional reimbursement. Providers do not need to resubmit the claims. Providers must follow the coding and billing requirements from CMS. This will apply to both in-network and out-of-network providers.

- **For in-network providers**, the increase will be applied, as appropriate, to payments to providers whose contracted reimbursement is based on the CMS inpatient prospective payment system.
- **For out-of-network providers**, the increase will be applied for Medicare Advantage members based on CMS requirements.

Temporary suspension of the Medicare sequestration fee
We will temporarily suspend the 2% Medicare sequestration fee for in-network providers based on the terms of your participation agreement with ConnectiCare. This temporary suspension applies to payments with dates of services or discharges from May 1, 2020 through Dec. 31, 2020.

Pre-payment forensic reviews and audits to resume June 20

ConnectiCare resumed its high-dollar, pre-payment forensic reviews as well as the post-payment diagnosis-related group (DRG) and implant audits on June 20, 2020. This applies to claims paid to facilities. Our partner, Equian, will retrospectively review the high-dollar claims that had qualified for pre-payment review and were paid during the coronavirus (COVID-19) crisis period.

Provider payments and other 2020 updates

Here are some upcoming changes to 2020 ConnectiCare plans and operations that will affect you and your patients:

1. It will be important for your office to check member ID cards for patients with employer-sponsored plans. ConnectiCare members with employer-sponsored plans will get new member ID cards with **new ID numbers**, starting with group plans that enroll or renew on Aug. 1, 2020.

2. We are continuing to make changes to how we pay claims to our providers as we align our processes with our parent company, EmblemHealth. We started in January with our Medicare Advantage claims for 2020 dates of service. We are continuing with our commercial claims, starting with new and renewing employer-sponsored plans on Aug. 1, 2020.

New member ID numbers and ID cards for employer-sponsored plans
Starting Aug. 1, 2020 through 2021, ConnectiCare commercial members with employer-sponsored plans will get new member ID numbers that begin with the letter "K." These members will get new ID cards that will also include new group ID numbers.

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

There are no changes to the claims submission process. But 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
We will continue to make changes to how we pay providers as follows:

- **Frequency of provider payments to increase:** We will move 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 our Medicare Advantage members since Jan. 1, 2020.
- **Changes to EFT registration and access to ERAs:** We will use PNC Bank and the ECHO Health payment platform to pay Medicare Advantage claims starting July 15, 2020 and commercial claims[2] starting Aug. 1, 2020. This means providers will need to go to the ECHO website:
  - 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.

  Please note, if you have already enrolled for EFT/ERA through PNC Bank's Remittance Advantage (PNC-RA) you don't have to do anything to continue receiving EFT/ERA after July 15. PNC Bank will move your bank account information and EFT payment preferences into the ECHO website, **providerpayments.com**.

  If you don't currently have log-in credentials for the ECHO website, you will be able to sign up for access through that website after July 15 for Medicare Advantage claims and Aug. 1 for commercial claims.

- **Virtual card payments after July 15 for Medicare claims, Aug. 1, 2020 for commercial claims:**[2] If you are not enrolled for EFT through the PNC-RA website or the ECHO website, your office will receive virtual credit card payments for your claims. You will get payment notifications via fax or mail, each containing your explanation of payment (EOP) along 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.

  You can avoid possible transaction fees by contacting ECHO to decline the initial virtual card payment, ask for a paper check for the full amount of the claims payment, and, if you like, opt into EFT through ECHO.

We will keep our providers updated throughout the year regarding these changes and other important information you need to know.

[2]*This only applies to commercial claims submitted after Aug. 1, 2020 for commercial members with the new ID numbers that start with the letter "K." You will still get EFT payments through Bank of America for claims submitted for commercial members with the old ID numbers.*

Biosimilar preferred product update

Starting July 1, 2020, ConnectiCare has selected preferred products for all lines of business for bevacizumab, trastuzumab and rituximab.

Members who received authorization prior to July 1, 2020 may continue treatment with the non-preferred drugs listed below. Non-Medicare Advantage members who start therapy on or after July 1, 2020 must have a trial and therapeutic failure of a preferred alternative drug prior to approval of a non-preferred drug.

Chemical name	Non-preferred drug(s)	Preferred alternative drug(s)
bevacizumab	Avastin (J9035)[3]	Mvasi (Q5107) Zirabev (Q5118)
trastuzumab	Herceptin (J9355) Herzuma (Q5113) Ontruzant (Q5112)	Kanjinti (Q5117) Ogivri (Q5114) Trazimera (Q5116)
rituximab	Rituxan (J9312)	Ruxience (J9999) Truxima (Q5115)

[3]*Oncology indications only*.

Preferred products also require preauthorization.

Below are our medical policies related to this update. Please note, these EmblemHealth policies apply to ConnectiCare. ConnectiCare and its affiliates are members of the EmblemHealth family of companies.

- Avastin (bevacizumab) (Intravenous)
- Mvasi (bevacizumab-awwb), Zirabev (bevacizumab-bvcr)
- Trastuzumab Injection (Herceptin, Herceptin Hylecta, Herzuma, Kanjinti, Ontruzant, Ogivri, Trazimera)

- Rituximab Injectable (Rituxan, Ruxience, Truxima)

New and updated payment policies, effective Aug. 1, 2020

Below are new and updated payment policies that will go into effect Aug. 1, 2020:

- **New multiple procedure reduction policy and updated multiple diagnostic imaging payment reduction policy:** ConnectiCare will be aligning with the Centers for Medicare & Medicaid Services (CMS) Multiple Procedure Payment Reduction (MPPR) Policy for commercial members. ConnectiCare has adopted CMS guidelines when multiple diagnostic cardiovascular procedures or diagnostic ophthalmology procedures are performed on the same day by providers who report under the same federal tax identification number (TIN). See the **Payment Policy: Multiple Procedure Payment Reduction Cardiology/Ophthalmology (Commercial and Medicare)** for details.
- **Multiple diagnostic imaging payment reduction policy** has also been updated to indicate that the professional component of the diagnostic imaging may also be subject to reductions in alignment with CMS. Here's the **Payment Policy: Multiple Diagnostic Imaging Payment Reduction (Commercial)**.
- **Updated laboratory policy for commercial and Medicare Advantage plans:** ConnectiCare will be aligning with CMS and the Federal Clinical Laboratory Improvement Amendments (CLIA) regulations. If you are a physician, practitioner or medical group, you may only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our members.

  We only reimburse for laboratory services that you are certified to perform through the federal CLIA. You must not bill our members for any laboratory services for which you lack the applicable CLIA certification. A valid federal CLIA Certificate Identification number is required for reimbursement of clinical laboratory services reported on a CMS 1500 Health Insurance Claim Form or its electronic equivalent.

See the **Payment Policy: Laboratory/Venipuncture (Commercial and Medicare)** for more details.

D-SNP provider training needs to be completed by Aug. 30

Providers who work with ConnectiCare's Medicare Advantage members with Choice Dual (HMO D-SNP) plans need to complete the Special Needs Plan Model of Care (SNP MOC) training no later than Aug. 30, 2020.

We sent letters to our participating providers earlier this month with instructions for how to access the training online. The training takes only 15 minutes to complete.

The Centers for Medicare & Medicaid Services (CMS) requires providers to complete training for each dual-eligible special needs plan (D-SNP) they participate in.

ConnectiCare providers who are in network for certain EmblemHealth plans

Providers for our commercial and Medicare Advantage plans can also treat certain EmblemHealth members. On Jan. 1, 2020, EmblemHealth, our parent company in New York, expanded one of its networks to include ConnectiCare Medicare Advantage providers in Connecticut. ConnectiCare commercial providers have been treating certain EmblemHealth members since 2017.

Here are the plans that allow EmblemHealth members to access the ConnectiCare provider network:

Network	EH HMO Prime network products that have access to ConnectiCare HMO network	Network	EH VIP Prime network products that have access to ConnectiCare Medicare Advantage network

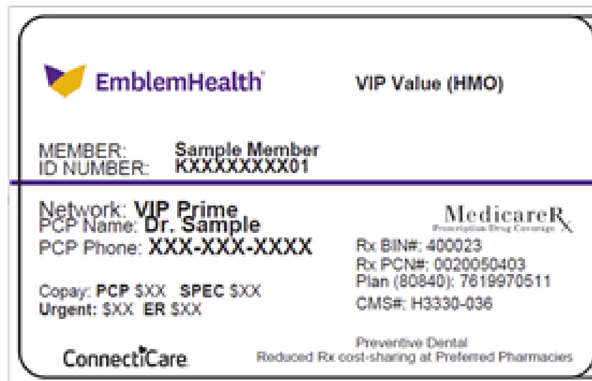
Large Groups	
PRIME	EH HMO Preferred Plus
PRIME	EH HMO Plus
PRIME	EPO Value HDHP
PRIME	EPO Value
PRIME	HIP HMO Preferred
PRIME	HIP Prime
PRIME	HIP access I
PRIME	HIP Prime POS
PRIME	HIP access II
PRIME	Vytra
PRIME	GHI HMO

Medicare	
VIP PRIME	EmblemHealth VIP Value
VIP PRIME	EmblemHealth VIP Essential
VIP PRIME	EmblemHealth VIP RX Saver
VIP PRIME	EmblemHealth VIP Part B Saver
VIP PRIME	EmblemHealth VIP Go
VIP PRIME	EmblemHealth VIP Gold
VIP PRIME	EmblemHealth VIP Gold Plus
VIP PRIME	EmblemHealth VIP Passport
VIP PRIME	EmblemHealth VIP Passport NYC
VIP PRIME	EmblemHealth Employer Groups

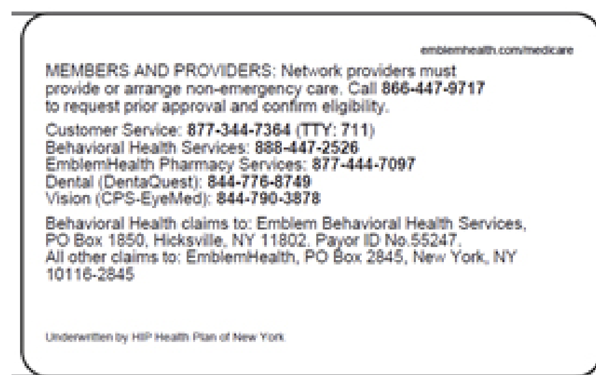
Network	EH HMO Prime network products that have access to ConnectiCare HMO network	Network	EH HMO Prime network products that have access to ConnectiCare HMO network

Small Groups			
PRIME	EmblemHealth Platinum Premier	PRIME	EmblemHealth Gold Value – P
PRIME	EmblemHealth Gold Premier 1	PRIME	EmblemHealth Gold Premier – P
PRIME	EmblemHealth Gold Plus	PRIME	EmblemHealth Silver Premier – P
PRIME	EmblemHealth Silver Plus 1	PRIME	EmblemHealth Silver Value - P
PRIME	EmblemHealth Silver Premier	PRIME	EmblemHealth Silver Plus H.S.A.
PRIME	EmblemHealth Bronze Plus H.S.A.	PRIME	EmblemHealth Bronze Premier - P
PRIME	EmblemHealth Healthy NY Gold	PRIME	EmblemHealth Bronze Value - P
PRIME	EmblemHealth Platinum Premier – P	PRIME	EmblemHealth Platinum POS
PRIME	EmblemHealth Platinum Value – P	PRIME	EmblemHealth Gold POS

EmblemHeath members with the above plans will have a member ID card with a ConnectiCare logo included, like the one illustrated below:



Front of EmblemHealth member ID card



Back of EmblemHealth member ID card

EmblemHealth members with the plans listed above can get medical care and services from ConnectiCare providers under their in-network benefits. For these members, EmblemHealth policies and procedures apply. Go to emblemhealth.com/provider or call 1-866-447-9717 for details.

Please note, claims need to be submitted to Emblem but will be paid according to your ConnectiCare contract.

Have your NPI handy when you call our Provider Services team

Starting next month, you will need your NPI (National Provider Identifier) when you call our commercial and Medicare Advantage Provider Services teams. This will help speed up responses to your calls. Please continue to have the name of the patient and his/her member ID number handy, too.

Submit taxonomy codes to help make sure claims are paid quickly

Here's a tip that may make a difference in how quickly your commercial and Medicare Advantage claims are paid: submit your taxonomy codes in both your paper and electronic claims submissions. Taxonomy codes allow your claims to be priced according to the Centers for Medicare & Medicaid Services' (CMS) established rates.

Submission of taxonomy codes is required for all Medicare claims submissions, and it is *highly recommended* for commercial claims.

Taxonomy codes are administrative codes that identify your provider type and specialization. A taxonomy code is a unique, 10-character, alphanumeric code that identifies your specialty at the claim level.

Information required in claims submissions are:

Provider data element	Inclusion condition	EDI location	Paper claim location
		Institutional claims	
Billing Provider Taxonomy Code	**Always include billing provider taxonomy code**. If Pay-to taxonomy code is different from the billing provider code, use the pay-to	2000A PRV01, 02, 03	33b

	provider taxonomy code.		
Attending Provider Taxonomy Code	Include if attending provider differs from 2000A PRV01, 02, 03	2310A PRV01, 02, 03	24I - add qualifier 'ZZ' 24J - enter taxonomy code in shaded and NPI in unshaded area
		Professional claims	
Billing Provider Taxonomy Code	**Always include billing provider taxonomy code**. If Pay-to taxonomy code is different from the billing provider code, use the pay-to provider taxonomy code.	2000A PRV01, 02, 03	33b
Rendering Provider Taxonomy Code (claim level)	Include if rendering provider differs from 2000A PRV01, 02, 03	2310B PRV01, 02, 03	24J - enter taxonomy code preceded by qualifier 'ZZ'
Rendering Provider Taxonomy Code (service level)	Include if service line rendering provider differs from 2310B PRV01, 02, 03	2420A PRV01, 02, 03	

CMS updates and publishes the Health Care Provider Taxonomy Code Set twice a year. Current codes can be found **on the CMS website**.

Checking your taxonomy code in NPPES
Please make sure your taxonomy code in the National Plan and Provider Enumeration System (NPPES) database is accurate.

Here's what you need to do:

1. Go to **npiregistry.cms.hhs.gov** and look up your NPI.
2. Click on the NPI number to view the full record, including the provider taxonomy codes. If the taxonomy codes are accurate, you're all set.
3. If the codes are incorrect, sign into **nppes.cms.hhs.gov/NPPES/Welcome.do** to manage and update your NPI and taxonomy code. The taxonomy code should be updated automatically.

Acupuncture for chronic lower back pain, a new benefit for some Medicare Advantage members

In compliance with the National Coverage Determination (NCD) requirements, ConnectiCare has begun to offer acupuncture for chronic lower back pain as a covered benefit for our Medicare Advantage members since Jan. 1, 2020. This is a benefit offered through our HMO, HMO-POS and HMO D-SNP plans.

Under the new benefit, covered services include up to 12 visits in 90 days for Medicare beneficiaries with chronic lower back, defined as:

- Lasting 12 weeks or longer,
- Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease),
- Not associated with surgery, and
- Not associated with pregnancy

An additional eight sessions will be covered for patients demonstrating improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is

regressing.

Preauthorization is required after the 12th visit.

Members will need to pay a $30 copay for each visit, unless they are members who are dual eligible for Medicare and Medicaid. Medicaid will pay the member's cost-share if the dual-eligible members goes to a Medicaid approved provider. Please note, Qualified Medicare Beneficiaries (QMB) cannot be billed.

Recent provider headlines

Check out the latest Provider News & Headlines:

- Get your claims payments sent directly to your bank accounts
- Medical record reviews to start this month
- Mental Health Awareness Month tip: Coordinate behavioral health and medical care
- New and updated medical policies
- Preauthorization determination is required for all non-emergency ambulance transports
- Ophthalmology: A reminder about Avastin dosage
- Has any of your information changed? Let us know.

Keep in touch

Coronavirus (COVID-19) articles: 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.

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