ConnectiCare
an EmblemHealth company

November 2020 - In this issue

What's new for 2021?

Here's what you need to know for the new year:

- **All commercial members will have new member ID numbers and ID cards:** By Jan. 1, 2021, all commercial members with employer-sponsored and individual plans will have new member ID numbers that start with the letter "K" followed by a 10-digit number. View a sample here.

  The new commercial member ID numbers are similar to those of our Medicare Advantage members. Medicare Advantage ID cards do clearly note the member has a Medicare Advantage plan.

  Please make sure to ask our commercial members for these ID cards. To avoid any delays in claims payments, please use the new ID cards for services on and after Jan. 1, 2021. Claims for 2021 services with old member numbers that start with the numeral "9" may be denied and returned for resubmission.

  It's important to check ID cards and ID numbers for all commercial patients at every visit and sign in to our provider website to verify eligibility.

  Please be aware that the explanation of payment statements (EOP) for services provided to members with the new K-ID will also change after Jan. 1. Here's a document to help you understand the new format.

  Provider payments will be made through our partnership with PNC Bank and the ECHO Health payment platform. If you haven't signed up for electronic funds transfer (EFT) through PNC-ECHO, you will receive your claims payment by virtual credit card. Normal transaction fees apply based on your merchant acquirer relationship. These virtual credit cards expire after 60 days.

- **Expanded pharmacy utilization management program now includes Medicare Advantage plans:** Earlier this year, we told you Express Scripts (ESI) will perform most drug utilization management services for all our ConnectiCare members with commercial plans, including plans sold

through Access Health CT. We're expanding that program to include Medicare Advantage plans starting Jan. 1, 2021. This means ESI will review requests for drug preauthorization, quantity limits and step therapy for all our commercial and Medicare Advantage plans in 2021.

This **will not** apply to most drug utilization management requests for adult chemotherapy and supportive agents. **New Century Health (NCH)** will need to preauthorize all **oncology-related chemotherapeutic drugs** and supportive agents when they're given to commercial (including Access Health CT) and Medicare Advantage patients in the physician's office, outpatient hospital or ambulatory setting.

Preauthorizations approved before Jan. 1
All preauthorizations for non-chemotherapeutic drugs and supportive agents for Medicare Advantage members issued by ConnectiCare before Jan. 1, 2021 will remain valid until they expire.

We know this is a lot of information and your offices are busy. Here's a drug preauthorization overview chart to help you.

- **New step therapy requirements for certain Part B drugs for Medicare Advantage plans:** Starting Jan. 1, 2021, we will implement step therapy requirements for our Medicare Advantage line of business for certain categories of Part B drugs.

  Members who received authorization before Jan. 1, 2021 may continue treatment with the non-preferred drugs listed on this chart. Members who start therapy on or after Jan. 1, 2021 must have a trial and therapeutic failure of a preferred alternative drug prior to approval of a non-preferred drug. Please note, preferred products also require preauthorization.

- **Medicare Advantage pharmacy network updates for 2021:** We've made some changes to our Medicare Advantage pharmacy network. We notified our members about the changes earlier this month. Please support your patients who may be affected by writing new prescription orders,

when needed, that they can take to a participating pharmacy before the new year.

- **2021 updates to our Medicare Advantage plans:** Here's how changes to our 2021 ConnectiCare Medicare Advantage plans will affect you and your patients:
    - **New expanded Medicare Advantage provider network:** VIP Bold in New York will replace the EmblemHealth VIP Prime Network and be accessible to ConnectiCare members with Choice or Flex plans. These members will present ConnectiCare ID cards that also have an EmblemHealth logo. This means your patients can visit New York health care professional and medical facilities in the new VIP Bold network for certain services after Jan. 1, 2021. Please note, the VIP Bold network does not apply to members with ConnectiCare Choice Dual (HMO D-SNP) and ConnectiCare Choice Dual Basic (HMO D-SNP) plans.
    - **Eligible EmblemHealth members** will also be able to get certain medical care and services from ConnectiCare providers like you. These members will present EmblemHealth ID cards that also have a ConnectiCare logo. If an EmblemHealth member presents an ID card without a ConnectiCare logo, it's best to check his or her eligibility on the EmblemHealth website.
    - **New dual special needs plan:** After Jan. 1, 2021, ConnectiCare will have two special needs plans — ConnectiCare Choice Dual (HMO D-SNP) and the new ConnectiCare Choice Dual Basic (HMO D-SNP). These plans do not have access to the VIP Bold network in New York.
    - **Telehealth benefits added to all plans** so our Medicare Advantage members with individual plans can visit their primary care doctors, specialists, or mental health clinicians from home. Medicare Advantage members with group plans can also visit primary care doctors and specialists using telehealth. Please note, this benefit will go into effect after the national public health emergency related to the coronavirus (COVID-19) ends. Our

temporary telehealth policy in response to COVID-19 remains in effect during the emergency.

New and updated policies, including medical policy for COVID-19 testing

The following policies have been created or updated:

- New Medical Policy: Testing for Coronavirus Disease 2019 (COVID-19) (Commercial & Medicare Advantage), effective Feb. 11, 2021
- Updated Payment Policy: ASC Grouper 2020 (Commercial), effective Oct. 1, 2020
- Updated Medical Necessity Guidelines: Experimental, Investigational or Unproven Services (Commercial & Medicare Advantage), effective Oct. 1, 2020
- Updated Medical Policy Preauthorization Criteria: Lymphedema Treatment (Commercial & Medicare Advantage), effective Oct. 9, 2020

You can find all policies on connecticare.com/providers.

Medicare Advantage and 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 inpatient reimbursement for both in-network and out-of-network COVID-19 care given to Medicare Advantage members.
- Effective with **admissions occurring on or after Sept. 1, 2020**, claims eligible for the 20% increase in the MS-DRG weighting factor will also **be required to have a positive COVID-19 laboratory test** documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with Centers for Disease Control and Prevention (CDC) guidelines. The test may be performed either during the hospital admission or no less than 14 days prior to the hospital admission.

This only applies to our members with Medicare Advantage plans.

Adding 20% to COVID-19 inpatient reimbursement
In accordance with Centers for Medicare & Medicaid Services (CMS) methodology, ConnectiCare will add 20% to the MS-DRG-based inpatient reimbursement (operating component only) for Medicare Advantage patients who were discharged with a COVID-19 diagnosis after Jan. 27, 2020.

Effective with Sept. 1, 2020 admission dates, CMS requires that a positive COVID test result be documented in the medical record for inpatient claims to be eligible for the 20% increase.

For all out-of-network and in-network hospitals

- Inpatient admission MS-DRG claims having COVID DX Code U07.1 as a primary diagnosis will process with the COVID Add-On. We may audit paid claims, and we may ask the hospital to provide medical records to validate the presence of a positive COVID test.
- Inpatient admission MS-DRG claims having COVID DX Code U07.1 as a secondary diagnosis will process without the COVID Add-On.
    - Claims will have a remittance message informing the provider that, if the COVID DRG Add-On is warranted, the provider is to submit medical records validating the documentation of a positive COVID lab test within 14 days of the admission date.
    - The claim will be adjusted to pay the COVID Add-On amount once ConnectiCare validates an eligible positive COVID test.

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.

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.

  MOON informs Medicare beneficiaries (including Medicare Advantage plan members) that they are receiving outpatient observation services and are not admitted as an 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 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 Medicare savings 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").

- **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.

- **Preventive annual physical exams are only covered when performed by primary care providers (PCPs).** ConnectiCare will only cover CPT codes 99381 through 99397 if the services are performed by PCPs. Obstetricians and gynecologists will only be reimbursed for the Medicare-covered annual pap/pelvic exam (CPT code G0101) to stay consistent with CMS reimbursement guidelines. Check out this 2019 provider headline for more details.

- **Routine eye exams are only covered if performed by an EyeMed provider.** Members can use the "Find a doctor" tool on connecticare.com to search for "Insight network" EyeMed providers in their areas.

Medicare contract-level risk adjustment data validation (RADV) audit is ongoing

From now through February, members of our Network Relations team may contact you to retrieve and review medical records of patients with ConnectiCare Medicare Advantage plans who were seen at your office in 2014.

The Centers for Medicare & Medicaid Services (CMS) asked ConnectiCare to undergo a contract-level risk adjustment data validation (RADV) audit on a small sample of members enrolled in a Medicare Advantage plan. To verify the accuracy of diagnosis date submitted, this audit requires us to submit supporting medical records on a limited population of members covered by the audit. The dates of service requested will be between Jan. 1, 2014 and Dec. 31, 2014.

ConnectiCare will contact your offices to coordinate chart retrieval and set the date when the records must be received.

Please respond to the requests for records promptly. This is a federally-mandated audit. Notice of the need for these reviews and your required compliance are

included in your contract with ConnectiCare.

We appreciate your help. If you have questions, please call our provider services department at 1-877-224-8230.

Help diabetic patients prevent vision loss

As the American Diabetes Association notes, people with diabetes have a higher risk of blindness than those without diabetes. But with regular checkups, you can help make sure your patients avoid major eye and vision problems.

Here's what you can do:

- Help your patients understand the importance of the annual retinal eye exams.
- Reach out to your patients who may be reluctant to have eye exams or may not be compliant.
- Call our case management team at 1-800-829-0696 if you need help.

If your patients do have their eyes examined:

- Review the ophthalmologist report and document any abnormalities.
- Include the report in a patient's medical record and note the date of service, practitioner's name and credentials.
- If a copy of the report isn't available, document in the patient's medical history the date of the eye exam, the result and name of practitioner (with the credentials) who conducted the exam.

An annual diabetic retinal eye exam is an important HEDIS measure. But, more importantly, it's good medical care.

New provider forms now available online

We have published the following new forms on connecticare.com/providers to help you submit requests and documentation to us:

- Medical Records Request Form (Commercial/Medicare Advantage): Providers must use this form when submitting medical records that ConnectiCare

requests. This is not to be used for appeals.

- Non-Urgent Transportation Request Form (Commercial/Medicare Advantage): Providers must use this form to request non-emergency transportation from all locations. For inpatient requests, the facility sending the member for transportation must send this completed form and supporting medical records to ConnectiCare for medical necessity review.

You can find all our forms here.

Keep your CAQH information current and accurate

It's important to authorize EmblemHealth, ConnectiCare's parent company, as an eligible plan to access your Council for Affordable Quality Healthcare, Inc. (CAQH) information so we can make sure your application is current and attested every 120 days. This enables us to complete an initial application or tri-annual recredentialing without having to send you additional paperwork to fill out. This way, you can avoid the risk of your application being discontinued or being terminated from our provider network.

Provider Services holiday hours

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

- Thursday, Nov. 26 (Thanksgiving)
- Friday, Dec. 25 (Christmas)
- Friday, Jan. 1, 2021 (New Year's Day)

Recent provider headlines

Check out the latest Provider News & Headlines:

- Here's what members said about their telehealth visits
- Check ID cards for all commercial patients at every visit
- Educate patients about the proper use of antibiotics to protect public health

- New and updated payment policies now available online
- Medical records review ongoing through March
- Best practices for children and adolescents on antipsychotics

Keep in touch