ConnectiCare
an EmblemHealth company

January 2021 - In this issue

The latest COVID-19 updates

Here's the latest coronavirus (COVID-19) news for you:

- The Temporary Payment Policy: Supplemental Telehealth Guidelines — Commercial/Medicare Advantage has been updated to reflect the extension of the federal public health emergency. It will now be in effect until the end of the COVID-19 public health emergency, unless amended.
- The Medical Policy: Testing for Coronavirus Disease 2019 (COVID-19) — Commercial/Medicare Advantage, effective Feb. 11, 2021, has been updated to include new 2021 codes.
- Language matters when communicating about COVID-19 vaccinations. EmblemHealth, ConnectiCare's parent company, conducted a study in anticipation of the national rollout of COVID-19 vaccinations. It found that people generally prefer the terms "vaccination" and "immunization" to "shot." Read details of the study – including its implications for conversations you have with patients.

Please refer to our dedicated COVID-19 page on our provider website for the latest news and the most up-to-date information.

Ask all commercial patients for their new ID cards and new member ID numbers

Just a reminder: **all commercial members received new member ID numbers** that went into effect Jan. 1, 2021. The new member ID numbers start with the letter "K" followed by a 10-digit number. View a sample here.

To avoid delays in claims payment, make sure to use the new member ID numbers for dates of services on and after Jan. 1, 2021.

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.

It's important to check ID cards and sign in to our provider website to verify the member's eligibility and member's plan.

Please be aware that the explanation of payment statements (EOPs) for services in 2021 will also change. Here's a document to help you understand the new format.

To avoid any delays in claims payments, please use the new ID numbers for services on and after Jan. 1, 2021. Claims for 2021 services with old member numbers (those started with the numeral "9") may be denied and returned for resubmission.

There are no changes to the claims submissions process. Continue to send claims to:

ConnectiCare
P.O. Box 546
Farmington, CT 06034-0546
Payer number: 06105
1-860-674-5850 or 1-800-828-3407

This information is on the back of the ID cards of ConnectiCare's commercial members.

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.

National Drug Code (NDC) requirements for drug claims

Starting April 19, 2021, a valid National Drug Code (NDC) number, unit of measure, and units dispensed for drugs administered by health care professionals in ambulatory care settings will be required on all professional and facility drug claims.

Electronic and paper claims submitted with missing, invalid, or incomplete NDC information, or where NDC does not match the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) codes

submitted, will be denied. Claims can be resubmitted with the appropriate NDC information for reconsideration.

NDC numbers are the industry standard identifier for drugs and provide full transparency to the medication administered. The NDC number identifies the manufacturer, drug name, dosage, strength, package size, and quantity. Including NDC information on claims will differentiate drugs that share the same HCPCS, CPT, or Revenue codes for drug preferences and enhance reimbursement processes.

For more information on NDC requirements including frequently asked questions, see the National Drug Code (NDC) Submissions Payment Policy.

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**.	2000A PRV01, 02, 03	81a with B3 qualifier
Attending Provider Taxonomy Code	Include if attending provider differs from 2000A PRV01, 02, 03	2310A PRV01, 02, 03	81b with B3 qualifier
		Professional claims	
Billing Provider Taxonomy Code	**Always include billing 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.

Reminder: New site-of-service utilization policy for Medicare goes into effect March 1, 2021

Our new Medical Policy: Site of Service Utilization for Medicare Advantage plans will go into effect March 1, 2021. Here are more details about the policy.

This policy applies to all Medicare Advantage members, including members with dual special needs plans (D-SNP).

Please remember, if service will be provided to a Medicare Advantage member in a preferred site after March 1, preauthorization will not be required.

For example, if you provide a colonoscopy at an ambulatory surgical center, you do not need to get prior approval. You only need preauthorization if the colonoscopy is scheduled after March 1 in a hospital setting.

Services listed in the office-based code list can be performed in a doctor's office without prior approval. Preauthorization will be required for these procedures to be performed at an ambulatory surgical center or outpatient hospital, including hospital-owned, off-campus facilities.

Services listed in the outpatient hospital code list do not require preauthorization when they are being done in an ambulatory surgical center. Preauthorization is required when the services are being performed in an outpatient hospital,

including hospital-owned, off-campus facilities.

Here's a table to help you understand when you need to submit a site-of-service preauthorization request for Medicare Advantage members after March 1, 2021

Services	Doctor's office	Ambulatory surgical center	Outpatient hospital, including hospital-owned, off-campus facilities
Services/ procedures on office-based code list	No preauthorization needed.	Yes, preauthorization required.	Yes, preauthorization required.
Services/ procedures on outpatient hospital code list	N/A	No preauthorization needed.	Yes, preauthorization required.

Annual HEDIS data collection to start next month

Our annual medical record review begins next month. HEDIS, which stands for Healthcare Effectiveness Data Information Set, is a National Committee for Quality Assurance (NCQA) tool used by health plans, like ConnectiCare, to measure performance of the services and care our members receive.

We use the results from the annual HEDIS review to improve the quality of members' care and strengthen our educational programs for providers and members.

If you have ConnectiCare members who are included in the random HEDIS

sample, we may request medical record information from your office. If this is the case, we may ask your office to provide the patients' medical records through:

- a scheduled visit to your office
- a medical record fax back or faxed request
- access to the patient's electronic medical record (EMR)
- an electronic exchange of information via a secure file transfer (FTP) site

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted, and the release of this information requires no special patient consent or authorization. Please be assured members' personal health information is maintained in accordance with all federal and state laws. Data is reported collectively without individual identifiers. All the health plans' contracted providers' records are protected by this.

We appreciate your cooperation and timely responses to our requests. You play an important role in promoting the health and wellness of our members. We will do what we can to work quickly and efficiently with you and your office staff to get the information needed.

New and updated policies now available online

The following policies are effective Jan. 1, 2021:

- Payment Policy: Prolonged Services (Commercial & Medicare): This is a new policy effective Jan. 1, 2021, when the Centers for Medicare & Medicaid Services (CMS) finalized HCPCS code G2212 for prolonged office/outpatient evaluation and management (E&M) visits. ConnectiCare is following CMS minimum time guidelines and allowing G2212 to be used with 99205 or 99215. Do not use 99358, 99359 or 99417 with code 99202-99215.
- Evaluation & Management (E&M) Codes Supplemental Policy: ConnectiCare will be updating the reimbursement policy to follow the revised 2021 Evaluation and Management (E&M) CPT® coding and guideline changes from the American Medical Association (AMA) and CMS.
- Payment Policy: ASC Grouper 2021 (Commercial): ConnectiCare has updated the ASC Grouper Policy to include new codes effective Jan. 1,

2021. Ambulatory surgical groupers will be paid according to surgical contracted rates when billed with revenue codes 360 or 490. If surgical services are billed with revenue codes other than 360 or 490 and the claims contain charges for anesthesia and/or recovery room, claims will be paid according to the surgical contracted rates unless otherwise negotiated.

- Medical Necessity Guidelines: Experimental, Investigational or Unproven Services (Commercial & Medicare): ConnectiCare has updated the Experimental, Investigational or Unproven Services Policy to include new codes effective Jan. 1, 2021. ConnectiCare defines the terms "investigational" or "experimental" as the use of a service, procedure or supply that is not recognized by the health plan as standard medical care for the condition, disease, illness or injury being treated. A service, procedure or supply includes, but is not limited to the diagnostic service, treatment, facility, equipment, drug or device.

Providers can access all our policies on connecticare.com/providers.

CPT® is a registered trademark of the American Medical Association.

New Part D Qualified Independent Contractor (QIC) starting Feb. 1, 2021

The Centers for Medicare & Medicaid Services (CMS) has awarded the Part D Qualified Independent Contractor (QIC) contract to C2C Innovative Solutions, Inc. (C2C).

Starting Feb. 1, 2021, C2C will be responsible for conducting reconsiderations of adverse Part D coverage determinations and redeterminations, adverse redeterminations related to an at-risk determination under a drug management program (DMP). For more information, check out this CMS memorandum.

Please note, MAXIMUS will continue to serve as the Part C QIC.

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.

Recent provider headlines

Check out the latest Provider News & Headlines:

- Commercial plan updates for 2021
- COVID-19 updates: Vaccine policy and SNF preauthorization
- Preauthorization policies updated, effective March 1, 2021
- New 2021 codes
- HCPCS/CPT coding requirements payment policy updated, effective Jan. 1, 2021
- Be on the lookout for 1099 tax forms for claims paid in 2020
- Need preauthorization for medical services? Call us.

Keep in touch