ConnectiCare
an EmblemHealth company

June 2021 - In This Issue

Now is the Time to Get Ready for Our New Provider Portal

We want the rollout of our new provider portal to be a positive experience for you. Here are some suggestions for things you can do now to get ready for the rollout.

If you already have a user account on our current provider portal and have accessed it within the 6 months prior to the upcoming rollout (planned for mid-July), we will migrate your access to the new portal. If you want your other account(s) to be migrated, please make sure you have signed into each account at least once before rollout day.

To prepare for this imminent transition, you will need to know your current user ID and password combinations, as well as security questions/answers for each account you use. If you have not set up a security question and answer or think you might not remember yours, **please take the time now to sign in to the current portal and update your choices,**. You will need:

- An active, current, and unique email address.
    - Going forward, you may no longer share email addresses across different users. Each portal account user must have a unique email address. You will use this email when you set up your password for the first time. You will also need your email if you ever need to retrieve/reset your password and username.
- An assigned Provider Portal Administrator/Office Manager for your practice/organization.

A supported web browser such as Google Chrome (recommended) or Microsoft Edge. The new portal will not work with Internet Explorer.

Frequently Asked Questions (FAQs)

We've put together these frequently asked questions, that includes answers to the most common questions we anticipate.

EmblemHealth FAQs ConnectiCare FAQs

Cancer Drug Preauthorization List Expand in August

Starting Aug. 15, 2021, ConnectiCare and EmblemHealth will require preauthorization for additional oncology-related chemotherapeutic drugs and supportive agents when delivered in the physician's office, outpatient hospital, or

other ambulatory setting. See ConnectiCare's Pharmacy Policies and EmblemHealth's Frequently Asked Questions: EmblemHealth Oncology Drug Management to determine where to submit the preauthorization request. Here are the lists of codes requiring preauthorization:

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ConnectiCare Commercial
ConnectiCare Medicare

COMMERCIAL BUSINESS UPDATE

July 1 – EmblemHealth Offering Bridge Program to Fully Insured Members

Starting July 1, EmblemHealth Plan, Inc., and EmblemHealth Insurance Company will offer existing large group benefit plan designs with access to the Bridge Program's combined five networks as an alternative to the current single-network access. The Bridge program is also available to both ConnectiCare and EmblemHealth employees and other ASO clients.

We created a new Bridge webpage to replace and enhance the Administrative Services Only (ASO) Bridge Program materials that have been available. The webpage should help you differentiate the ASO self-funded Bridge Program plans administered by EmblemHealth Insurance Company from the new, fully insured plans, and help you understand which administrative guidelines to follow. All plans will continue to follow the same Bridge Program payment protocols.

July is Ultraviolet Safety Month

July is Ultraviolet (UV) Safety Month. The goal is to raise awareness about the importance of protecting your skin and eyes from the harmful effects of UV rays and to prevent skin cancer, the most common cancer in the U.S. Talk to your patients about the importance of using a broad spectrum (UVA/UVB) sunscreen with an SPF (sun protection factor) of 15 or higher every day. More sun safety tips for our members to help protect themselves and their families are available on the following websites:

- The American Academy of Dermatology
- The Centers for Disease Control and Prevention
- The Skin Cancer Foundation

MEDICARE UPDATE

Medicare Outpatient Observation Notice (MOON)

CMS requires all hospitals and critical access hospitals to provide Medicare beneficiaries, including Medicare Advantage enrollees, with the OMB-approved Medicare Outpatient Observation Notice (MOON). The MOON and instructions for completing it are available on CMS's website.

New and Updated Policies Now Available Online

Payment Integrity Policies
The Payment Integrity Administrative Policy: Pre/Post Pay Claim Reviews criteria is being formalized in policy format effective **Aug. 1, 2021**. We routinely evaluate claims for coding, billing accuracy, and appropriateness. Providers are required to supply requested supporting information such as itemized bills and medical records. It is the billing provider's responsibility to ensure their responses are both prompt and complete. Note: Neither additional records nor amended records will be accepted once an audit review is complete.

Enterprise Version

In addition, we are adding outpatient APC audits to our payment integrity correct coding evaluations effective Aug. 1, 2021. We have contracted with Optum to perform these audits on our behalf. Notification via letters, their audit findings, and instructions on how to appeal their determinations will be coming directly from Optum.

Reimbursement Policies
All Reimbursement Policies are available for download from our provider websites.

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Coding Updates
Effective Aug. 31, 2021, the Diagnosis Code Guidelines: Manifestation/Secondary Diagnosis Codes is a new policy added for EmblemHealth to address Manifestation and Secondary Diagnosis Codes. EmblemHealth will follow the ICD-10-CM Official Guidelines for Coding and Reporting.

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Effective **Sept. 1, 2021**, we are introducing these new and updated policies:

Modifier JW – Drug and Biologicals – Modifier JW is appended when a physician, hospital, or other provider/supplier must discard the remainder of a single use/dose vial or other single use/dose package after administering a dose of the drug or biological. Reimbursement will be made for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label provided appropriate criteria are met. Per CMS, it is not appropriate to bill discarded or wasted amounts of drugs from multi-dose vials/multi-use packages with modifier JW; these claims will be denied. Note: A drug billed with modifier JW Is not payable when another claim line does not exist for the same drug on the same date of service. To minimize waste, the units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.

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The Modifier Reference Policy (Commercial) has been updated to align certain codes with CMS.

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The *Multiple Endoscopy-Pay Percent* is a new policy. We will begin editing endoscopic procedure codes billed to align with CMS guidelines. Edits will apply to multiple endoscopic procedures performed for the same patient, by the same provider, on the same date of service. The editing rules will, for example, look for multiple endoscopies billed, determine when multiple base procedure codes in the same family are incorrectly billed, and apply the multiple procedure cutback. The Relative Value Unit will be used when calculating the multiple endoscopy reduction. In addition to an adjustment based on the multiple endoscopy and multiple surgery guidelines, adjustments may also be made based on the following concepts: Bilateral, Multiple Quantity, and Payment Modifiers.

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The *Never Events/Adverse Events & Serious Reportable Events* (Commercial) policy is being updated to indicate that any procedure billed with modifier PA (Surgical or other invasive procedure on wrong body part), PB (Surgical or other invasive procedure on wrong patient), or PC (Wrong surgery or other invasive procedure on patient) is not payable.

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The *Co-Surgeon/Team Surgeon – Modifiers 62/66* is a new policy intended to serve as a general reference guide for the appropriate use of modifiers 62 or 66 when appended to procedures submitted on professional claims for physicians or other qualified health care professionals.

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The *Team Surgery Policy (Modifier 66)* a is new update to the ConnectiCare Coding Edits Policy. Procedures billed with modifier 66 are not payable when there exists a previously processed claim for the same procedure code without modifier 66 by any provider in accordance with CMS's guidelines.

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EmblemHealth has instituted a payment policy for duplicate claims for drugs effective **Sept. 15, 2021**.

New Coding Policies

Effective **Oct. 1, 2021**, we are introducing these 11 new coding policies:

The Medically Unlikely Edits (MUE) – Outpatient and Medically Unlikely Edits (MUE) – Practitioner policies will identify claim lines where the CMS Facility or Practitioner MUE has been exceeded for a CPT/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not.

The Unbundled Pair (CMS) policy will identify claim lines containing Procedure Codes that are typically not recommended for reimbursement when submitted with certain other Procedure Codes on the same date of service. Provider matching will be based on Tax Identification Number (TIN) and Specialty.

The Pay Percent Professional EM Rule applies pay percent recommendations to professional claims when a well visit/preventive exam, and any other Evaluation and Management (E&M) code(s), are billed for the same patient, same provider, and same date of service regardless of any modifiers.

*The LCD Procedure/Diagnosis_ FREQ_* Multi-diagnosis Rule identifies Professional and Outpatient Facility claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to Local Coverage Determinations (LCDs).

The LCD Medical Necessity ICD-10 Rule identifies Professional and Outpatient Facility claim lines for certain procedure codes associated with diagnoses where the procedure is not considered medically necessary, payable, or has payment constraints according to Part A and Part B Local Coverage Determinations (LCDs).

The NCD Procedure to Diagnosis - Exclusionary Lab Rule identifies Professional and Outpatient Facility claim lines where laboratory procedures are not considered medically necessary or payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Policy for Laboratory Procedures.

The NCD Procedure to Diagnosis - Inclusionary Lab Rule: Identifies Professional and Outpatient Facility claim lines where laboratory procedures are not considered medically necessary or payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Policy for Laboratory Procedures. This Inclusionary policy is based on the CMS defined list of "ICD-10-CM Codes Covered by Medicare Program".

The NCD Procedure to Diagnosis - Non-Covered Rule identifies Professional and Outpatient Facility claim lines submitted for procedure codes paired with specific diagnoses for which that code pair is defined as non-covered or not payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Determination Policy (NCD).

The NCD Procedure to Diagnosis - Covered Rule identifies Professional and Outpatient Facility claim lines for procedure codes not submitted with a covered diagnosis and is therefore defined as non-covered or not payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Determination Policy (NCD).

The NCD Procedure to Diagnosis Coverage Rule identifies Professional and Outpatient Facility claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to National Coverage Determinations (NCDs).

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Recent Provider Headlines

Check out recent provider news:

- Triannual recredentialing: CAQH accuracy is key
- Do not bill dual-eligible and QMB members with full Medicare benefits
- New provider portal – what to expect next
- Bridge Program to expand to non-ASO members

Keep in Touch