PROVIDER
UPDATE
MAY 1, 2019

NEWS FOR THE NETWORK

ABOUT: *PROVIDER UPDATE* NEWSLETTER

Provider Update is CarePartners of Connecticut's quarterly newsletter for providers, hospital administrators and ancillary providers in the CarePartners of Connecticut network. *Provider Update* is CarePartners of Connecticut's primary vehicle for providing 60-day notifications and other critical business-related information to providers.

PUBLICATION SCHEDULE

The CarePartners of Connecticut *Provider Update* newsletter is published on February 1, May 1, August 1 and November 1, and contains 60-day notifications effective for dates of service on or after April 1, July 1, October 1 and January 1.

WHERE CAN I FIND *PROVIDER UPDATE*?

On the Public Website: Current and recent past issues of the CarePartners of Connecticut *Provider Update* newsletter are available in the Provider News section of the public Provider website at carepartnersct.com/for-providers. The newsletter can be found in full PDF format, as well as by each individual article.

By Email: Providers and office staff are able to register for *Provider Update* by completing the online registration form, available in the News section of the CarePartners of Connecticut public Provider website.

In Print: CarePartners of Connecticut will not mail the full *Provider Update* newsletter to providers. Instead, a high-level, one-page mailing will be distributed quarterly to contracting providers, highlighting the 60-day notifications and pointing providers to the News section of the CarePartners of Connecticut public Provider website so they can read articles and register to receive *Provider Update* by email.

Note: Providers are encouraged to register to receive the newsletter by email as outlined above.

60-DAY NOTIFICATIONS

CORRECT CODING REMINDER

As a routine business practice, claims are subject to payment edits that are updated at regular intervals and generally based on CMS (including the National Correct Coding Initiative [NCCI] edits), specialty society guidelines and drug manufacturers' package label inserts.

Procedure and diagnosis codes undergo periodic revision by CMS (including NCCI edits) and the AMA. As these revisions are made public, CarePartners of Connecticut will update its systems to reflect these changes.

Documentation is updated to reflect the addition and replacement of procedure codes, where applicable.

BROWSER NOTE

If you are using an outdated or unsupported browser, certain features on CarePartners of Connecticut's websites may be unavailable. For an improved user experience, upgrade your browser to the latest version of Mozilla Firefox or Google Chrome.

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CLAIM EDITS

The following claim edits are effective for dates of service on or after July 1, 2019. These policies are derived from CMS, the AMA's Current Procedural Terminology Manual, the Healthcare Common Procedure Coding System, ICD-10, nationally accredited societies and CarePartners of Connecticut policy.

CarePartners of Connecticut will implement the following claim edits:

- Cardiology
- Claims processing parameters
- CMS coverage policies
- CMS National Coverage Determination (NCD) policies
- Duplicate services
- Durable medical equipment
- Global surgery
- Laboratory – pathology
- Neurology

These edits are documented in the applicable CarePartners of Connecticut payment policies available in the Resource Center.

CHANGE IN PROCESS FOR DRG VALIDATION

Effective July 1, 2019, CarePartners of Connecticut will implement changes to the DRG Validation of Inpatient Hospitals Policy. As part of this change:

- Providers will no longer be required to submit a corrected claim(s) following a change determination from Cotiviti.
- If a provider disagrees with a change determination, the provider may submit an appeal to CarePartners of Connecticut within 60 days from the date of the change determination letter. Should a provider disagree with the first-level appeal determination, they may submit a second-level appeal within 60 days of the date of the first-level appeal determination.
- If a provider does not appeal the change determination within the time frame allowed, CarePartners of Connecticut will adjust the data on the applicable claim(s) to match the change determination. Effective July 1, 2019, CarePartners of Connecticut will correct claims based on Cotiviti's determination, and submission of a corrected claim will no longer be required.
- Claims will be adjusted based on the DRG reassignment identified in Cotiviti's determination.

These changes to the DRG Validation for Inpatient Hospitals Policy will apply to all Cotiviti findings beginning on July 1, 2019, based on the date of the change determination letter.

As a reminder, a change determination by Cotiviti indicates that the medical record request and supporting documentation did not appropriately substantiate the original billing for services. The change determination identifies the proposed DRG reassignment. Contracting providers may not bill the member for any reimbursement differences that result from the audit.

This change is documented in the DRG Validation for Inpatient Hospitals Policy. For questions, please contact Provider Services at 888.341.1508.

REGISTER TO RECEIVE *PROVIDER UPDATE* BY EMAIL

Providers who have not yet registered to receive the CarePartners of Connecticut *Provider Update* newsletter by email must complete the online registration form, available in the News* section of the CarePartners of Connecticut public Provider website.

Providers who routinely visit the public Provider website for updates and who prefer not to receive *Provider Update* by email will have the opportunity to indicate that preference on the online registration form.

Note: If you have registered to receive *Provider Update* by email but are still not receiving it, you must check your spam folder or check with your organization's system administrator to ensure the organization's firewall is adjusted to allow for receipt of *Provider Update* (SENDER: providerupdate@email-carepartnersct.com).

The current issue of *Provider Update* is also available in printable format in the News section of the CarePartners of Connecticut public Provider website.

*If you do not register to receive CarePartners of Connecticut's *Provider Update* newsletter by email, copies of the full issue can be mailed upon request by calling 888.341.1508.

SUBMIT TRANSACTIONS ELECTRONICALLY USING ONLINE SELF-SERVICE CHANNELS

CarePartners of Connecticut's online self-service tools enable providers to submit transactions and/or access information related to claims submission, claims status, referrals, prior authorizations, electronic remittance advice, member eligibility, panel information, etc., electronically. Log in to the secure Provider website to handle transactions online.

Not Yet Registered?

Information on how to register for secure access is available on CarePartners of Connecticut's public Provider website.

HOW TO ENROLL FOR ELECTRONIC CLAIMS SUBMISSION

As members begin scheduling appointments and providers begin submitting claims, it is crucial to set up accurate claims submission processes with CarePartners of Connecticut to ensure timely processing and payment of claims. CarePartners of Connecticut encourages electronic submission be made directly to CarePartners of Connecticut, though claims submitted through clearinghouses will also be accepted.

Claims submitted directly to CarePartners of Connecticut must be in HIPAA-compliant standard 837 formats and include all required information. Providers who would like to submit claims through clearinghouses should contact their clearinghouse and ask that they start the process of setting up Payor ID 16307.

For more information, refer to the Claims Submission chapter of the CarePartners of Connecticut Provider Manual. For questions regarding submitting electronic claims directly or through a clearinghouse, contact the EDI Operations Department at 1.888.631.7002, ext. 52994, or email EDI_CT_Operations@carepartnersct.com.

PROVIDER TRAINING

This spring, CarePartners of Connecticut is offering a series of orientation webinars for provider office staff. Each webinar will cover a variety of topics including plan descriptions, policy overviews and online resources for providers. Additionally, attendees will have the opportunity to ask in-depth questions about the topics that are important to their practice.

To view the dates of CarePartners of Connecticut's current offerings and register to attend a webinar, visit the webinar page of the Training section on CarePartners of Connecticut's public Provider website.

The Training section also provides printable guides and resources to assist staff with day-to-day operations. Providers will find visuals with step-by-step instructions on how to navigate the secure Provider website to view claims, submit claims adjustments, view authorizations and more.

For questions regarding provider office staff education, or to request that a specific topic be addressed in an upcoming webinar or training video, email Provider Education at Provider_Training@carepartnersct.com.

MEDICARE ADVANTAGE PLAN OPTIONS

CarePartners of Connecticut offers three Medicare Advantage plan options, Preferred, Prime and Premier, which offer more extensive benefits than Original Medicare coverage alone. These Medicare Advantage plans are not a supplement to Original Medicare.

Plans provide members with Medicare Part A and Part B benefits, in addition to annual physicals, annual wellness visits, vision, hearing, prescriptions and reimbursements for eyewear, fitness, wellness programs, acupuncture and optional dental coverage. Monthly plan premiums are as low as $0, and include worldwide emergency and urgent care, and a cap on out-of-pocket medical expenses.

To learn more about how CarePartners of Connecticut can help your Medicare-eligible patients, call 844.353.5754 (TTY: 711), seven days a week, 8 a.m.–8 p.m. (April 1–September 30, Monday–Friday, 8 a.m.–8 p.m.).

MEDHOK MEDICAL MANAGEMENT SYSTEM

Providers logged in to the secure Provider website are able to use the MedHOK system to complete requests for inpatient and outpatient services, attach documentation, check authorization requests, and in some cases, receive a real-time determination online.

Submitting requests using the MedHOK system is the quickest, most direct way to submit requests to CarePartners of Connecticut for review. CarePartners of Connecticut encourages providers to use the MedHOK system to submit requests, as faxing increases the time it takes CarePartners of Connecticut to process requests.

If you are not yet a registered user of the secure Provider website, registration information is available on CarePartners of Connecticut's public Provider website. For questions about registration, please contact CarePartners of Connecticut's Provider Services at 888.341.1508.

A MedHOK Provider Portal User Guide will also be available in the Provider Resource Center later this year.

PROVIDER RESOURCE CENTER

The Provider Resource Center is a central repository on CarePartners of Connecticut's public Provider website where providers and office staff can find provider documentation including, but not limited to, the Provider Manual, payment policies, forms, and clinical and prior authorization criteria.

To access the Provider Resource Center, visit the CarePartners of Connecticut website, hover over For Providers in the upper right-hand corner, and then select Provider Resource Center.

HEDIS MEDICATION RECONCILIATION POST DISCHARGE

Management of member transitions is key to maintaining continuity of care and ensuring appropriate follow-up post-acute discharge, as well as to reducing inpatient readmissions. CMS, NCQA and subsequently CarePartners of Connecticut measure performance on important dimensions of transition management.

Historically, CMS has included the HEDIS Medication Reconciliation Post Discharge (MPR) Measure in the Medicare STAR Rating Program. This is a measure of discharges (from January 1 through December 1 of the calendar year) for members 18 years of age and older, for whom medications were reconciled with the date of inpatient discharge through 30 days after discharge.

The medication reconciliation must have been conducted by a prescribing provider, clinical pharmacist or registered nurse. Documentation in the medical record must include evidence of medication reconciliation and the date on which it was performed. Either of the following meets the criteria:

- Documentation that the provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinuation of all discharge medications)

Note: The current medication list must be documented in the outpatient medical record.

HEDIS COMPREHENSIVE CARE FOR DIABETES

HEDIS Comprehensive Care for Diabetes (CCD) continues to be a core measure of health plan performance, as well as provider effectiveness of care. This measures the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who have had each of the following:

- Hemoglobin A1c (HbA1c) testing:
  - Glycohemoglobin, glycated hemoglobin and glycosylated hemoglobin are acceptable HbA1c tests
  - There must be at least one test performed per year
- HbA1c poor control (>9%)* and HbA1c control (<8%):
  - Counts the results of the last test in the measurement year
  - No test done is counted as poorly controlled
- Diabetic eye exam (retinal)*:
  - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or
  - A negative retinal or dilated eye exam (negative for retinopathy) must be evaluated by an eye care professional in the year prior to the measurement year
- Medical attention for nephropathy*:
  - A urine test for albumin or protein
  - Evidence of treatment for nephropathy
  - Evidence of ESRD or of a kidney transplant
  - A visit with a nephrologist
  - An ACE inhibitor or ARB dispensing event
- Blood pressure control (<140/90mmHg):
  - Counts the last reading in the measurement year

*These measures are also part of the CMS Star Rating Program.

To ensure members with diabetes receive comprehensive care, providers are asked to:

- Maintain registries containing the statuses of the above components of care for members with diabetes. This should include reminder and recall systems, particularly for members who need more frequent follow-up due to poor HbA1c and/or poor blood pressure control.
- Provide timely follow-up on lab test results and on referrals to eye care professionals
- Utilize diabetic educators, or similarly trained personnel, to assist members with self-management techniques
- Refer members for care management when any of the following are identified: multiple co-morbid medical conditions, histories of admission and/or readmission, anticipated benefit from continued health coaching and support

To learn more about working with a care manager, email CM_CPCT@carepartnersct.com.

FOR MORE INFORMATION

WEBSITES

- Public Provider Website
- Secure Provider Website

CONTACT INFORMATION

- Call Provider Services at 888.341.1508 weekdays 8 a.m.–5 p.m.

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