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Welcome to the June edition of *In the Know*.

In this issue you'll find information about our new provider portal planned for July, our Bridge Program expanding to fully insured health plans, updated cancer drug preauthorization rules, National HIV Testing Day, Health Care Transparency in Cost and Quality Information, COBRA regulations during COVID-19, payment policies, coding, and more.

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 Expands in August

Starting **Aug. 15, 2021**, 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 EmblemHealth's **Frequently Asked Questions: EmblemHealth Oncology Drug Management** and **ConnectiCare's Pharmacy Policies** to determine where to submit the preauthorization request. Here are the lists of codes requiring preauthorization:

EmblemHealth | ConnectiCare Commercial | ConnectiCare Medicare

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National HIV Testing Day

According to the **Centers for Disease Control and Prevention (CDC)**, about 1.2 million people in the U.S. have HIV. June 27 is **National HIV Testing Day**, so encourage your patients between the ages of 13 and 64 to get tested for HIV at least once as part of routine health care. There are more HIV testing options available than ever before.

For your patients who have a confirmed HIV diagnosis, continue to educate them on the importance of consistent antiretroviral therapy, even if they feel well, and schedule follow-up visits to check progress.

If you need help managing your patients' need, you can enroll your patients in our Care Management program by calling **800-447-0768** Monday through Friday, 9 a.m. to 5 p.m. Members can find more information about living with HIV on our **website**.

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 our **website** and on the following websites:

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

COMMERICAL 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.

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.

Reminder: New Names You Should Know

Late last year, we announced we were retiring the Group Health Incorporated (GHI) and HIP Insurance Company of New York (HIPIC) names and replacing them with names that reflect our EmblemHealth identity.

Coverage and benefits remain the same. The name changes do not affect how you work with us or our members. It's simply new names for the companies as noted below that have been part of your practice for years.

Former Name	NEW Name
Group Health Incorporated (GHI)	EmblemHealth Plan, Inc.
HIP Insurance Company of New York (HIPIC)	EmblemHealth Insurance Company

GOVERNMENT-SPONSORED PROGRAM UPDATES

MEDICARE

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.

EMBLEMHEALTH'S MEDICAID, HARP, AND CHILD

HEALTH PLUS UPDATES (NEW YORK STATE-SPONSORED PROGRAMS)

Reminder: Taxonomy Code Enforcement for Medicaid Claims

To prevent your Medicaid claims from being rejected as “unclean,” be sure to include required **Taxonomy Codes**. Enforcement protocols should be fully implemented by the end of 3Q 2021.

Reminder: Submit Missing Participating Provider Owner/Manager Disclosure Certifications

Our Enhanced Care Prime Network providers must have a **Participating Provider Owner/Manager Disclosure Certification** on file with us. This is a New York State Department of Health requirement for Medicaid-managed care participation. If you have an agreement that is missing this document, please take a few minutes to **fill it out and submit the Certification online** to ensure compliance.

Reminder: Services for Children/Youth in a Voluntary Foster Care Agency

Effective July 1, 2021, all children and youth ages 21 and under who are currently in a Voluntary Foster Care Agency (VFCA) may receive five Core Limited Health-Related Services, provided the VCFA has an Article 29-I license and all required New York State certifications, designations and/or licenses. We have created a dedicated section of our provider website,
29-I VFCA Health Facility Providers,
which includes useful resource guides and a video presentation we invite all our Medicaid providers to watch.

Change of Address (and Contact) Notification

Providers must notify Medicaid of any change of address, telephone number, or other pertinent information within **15 days of the change**. For more detail on this requirement and how to submit changes, click to read **Reminder: Keep Your Directory Data Current**.

Medicaid: New York State Medicaid Update

The Office of Health Insurance Programs of the New York State

Department of Health regularly posts a Medicaid Update. Click **here** to view their latest announcements.

CLAIMS CORNER

The **Claims Corner** section of our EmblemHealth website is a rich source of information that helps your practice navigate EmblemHealth claims and billing processes. To make EmblemHealth's Payment Integrity Policies easy to find, we have added a new web page to Claims Corner. Similar information may be found on our ConnectiCare website under Our Policies and Billing and Claims. Please check often to see new postings.

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.
EmblemHealth
ConnectiCare

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.

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

- Following New York State Medicaid guidelines, EmblemHealth has instituted a **Medical Policy for Allergy Testing** effective **Sept. 15, 2021**.

- Following New York State Medicaid guidelines, EmblemHealth has instituted a **Medical Policy for Smoking and Tobacco Cessation** Counseling effective **Sept. 15, 2021**.

Mid-Level Practitioner Reimbursement Policy (Commercial) formalizes information previously housed in the Credentialing chapter of the EmblemHealth Provider Manual.

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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.

  - EmblemHealth
  - ConnectiCare

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

- 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.
  - EmblemHealth
  - ConnectiCare

- 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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- ConnectiCare

- 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.
  - EmblemHealth
  - ConnectiCare

- 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.
  - ConnectiCare

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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CLINICAL CORNER

Medical Policy Updates

All EmblemHealth **Medical Policies** are available for download in Clinical Corner on our provider website. The following are the recently revised policies:

- Cosmetic Surgery Procedures
- Outpatient Cardiac Rehabilitation
- Selective Internal Radiation Therapy
- Stereotactic Radiosurgery and Proton Beam Therapy
- Vacuum-Assisted Wound Closure

WEBINAR/TRAINING

EmblemHealth has enhanced the **Learning Online** section of its provider website to make it easier for you to register for monthly webinars (next one is July 14: 10-11 a.m. or 2-3 p.m.); meet and attest to completion of required trainings for Medicaid and Medicare providers such as Medicaid Cultural Competency and Special Needs Model of Care; and access the free Pulse8 webinars for patient management and ICD-10 coding.
We also recommend that you take advantage of the training opportunities offered by **CMS's Medicare Learning Network** and **eMedNY**.

IN EVERY ISSUE

Please keep your email address current so we can get information to you quickly.

Keep Your Directory and Other Information Current

If a provider in your practice is leaving, **please inform us** as soon as possible. To report other changes, you can also sign in to your Provider/Practice Profile on our **website**.

If you participate with us under a delegated credentialing agreement, please have your administrator submit these changes.

Remember to review your CAQH application every 120 days and ensure you have authorized EmblemHealth as an eligible plan to access your CAQH information.

EmblemHealth Neighborhood Care

New: Neighborhood Care has recently added on demand classes for meditation, chair yoga, and diabetes self-care. All classes are offered for free to you and all of your patients.
EmblemHealth Neighborhood Care offers our plan members and other community members a place to get the personalized, one-on-one support of experts in clinical, benefits, and health management solutions in support of a holistic approach to health and wellness. **Neighborhood Care** does not provide medical services; their role is to help practitioners manage patient care by supporting the primary practitioner-patient relationship. See **virtual classes** currently being offered.

In Case You Missed It – In the Know Archives Available

If you missed an edition of In the Know, or have trouble opening a link in this one, please see all our newsletters on our **website**.

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