CarePartners of Connecticut MEDICARE ADVANTAGE

Provider Update

NEWS FOR THE NETWORK

December 2024

Provider Update is a monthly, online provider newsletter. We encourage you to register to receive *Provider Update* by email. If you have registered for email distribution but aren't receiving *Provider Update* at the beginning of each month, look in 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* from (SENDER: providerupdate@email-carepartnersct.com).

Reminders and Updates

New HEDIS tip sheets for SPC and FMC measures

CarePartners of Connecticut is pleased to introduce HEDIS® tip sheets for the following measures:

- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Follow Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

The best practices highlighted within these new tip sheets are intended to support your practice by ensuring that the data reported accurately reflects your practice's performance and identifying opportunities to improve patient care.

For the full collection of CarePartners of Connecticut's current HEDIS tip sheets, please refer to the HEDIS tip sheet page on our provider website.

We will continue to inform you when we introduce new tip sheets. Be sure to look to future issues of Provider Update for the latest developments.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).◆

Utilization and care management delegation reminder

As we announced in last month's issue of Provider Update, beginning Jan. 1, 2025, CarePartners of Connecticut will delegate care management and utilization management of medical services and Medicare Part B drugs for members with an Advantage Plus Network – Connecticut (APN-CT) primary care provider to APN-CT, a partnership of Optum® and Hartford Healthcare. Part D pharmacy benefit drugs will continue to be reviewed by CarePartners of Connecticut.

Current CarePartners of Connecticut prior authorization requirements and medical necessity guidelines will continue to apply for these members.

How to obtain prior authorization through APN-CT

If you are aware that one of your CarePartners of Connecticut patients has an APN-CT primary care provider (PCP), you can request authorization for medical services and Part B drugs directly with APN-CT. You can submit the request to APN-CT in one of the following ways:

- **Online:** via the Optum Pro portal at optumproportal.com (Have questions? Select *Contact Us* in the portal to submit your question or issue.)
- **Phone: 1-888-556-7048**, 8 a.m.–6 p.m. ET, Monday–Friday (only if online unavailable)

If you are unsure whether the patient has an APN-CT PCP, continue to utilize the CarePartners of Connecticut provider portal as you do today; in the event that the patient does fall under this delegation agreement, you will be automatically redirected to the Optum Pro portal.

Register for Optum Pro

If you don't have an Optum Pro account, please register for an account today to get started. Registered users have access to several eLearning resources to help navigate the portal. To view eLearnings:

- Sign in to Optum Pro
- Select Education & Training from the navigation ribbon on the left
- eLearnings are available in the Activity section:
  - Select + to expand the collapsed *Activity* section
  - Select *Start* to begin the eLearning(s) in the expanded *Activity* section

For additional support, contact APN-CT at **1-888-556-7048,** 8 a.m.–6 p.m. ET, Monday–Friday.

Appeals and claims

This delegation only includes utilization management and care management. Please continue to follow the existing process for all other requests including:

- **Appeals:** If a prior authorization is denied by APN-CT, you or the member have the option to file an appeal through CarePartners of Connecticut.
- **Claims:** Submit claims to CarePartners of Connecticut. For the fastest processing time, we recommend submitting claims electronically.

For further guidance on these transactions, please refer to the CarePartners of Connecticut Provider Manual.◆

Timely filing limit increasing to 120 days

We understand that throughout the process of submitting claims, providers may sometimes face unexpected delays. CarePartners of Connecticut is committed to working collaboratively with our valued provider partners and we're always looking for ways to make your experience of doing business with us a positive one. To that end, and to support you with additional flexibility, we're increasing our standard timely filing limit from 60 days to 120 days for claims with dates of service on or after Jan. 1, 2025. For inpatient claims, the timely filing limit will be 120 days from the date of the hospital discharge.

In the coming weeks, you will receive a contract amendment that reflects the change to our timely filing limit. There is nothing you need to do.

For quick, efficient claims processing, we encourage providers to submit claims electronically. Please refer to the Claims section of the CarePartners of Connecticut Provider Manual for more information on our claims process.◆

Submit corrected claims electronically for timely processing

While CarePartners of Connecticut accepts electronic, online, and paper corrected claims, we would like to remind our provider network that electronic submission is the preferred method for efficient and timely claims processing.

A corrected claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates of service, member information) — it is not an inquiry or appeal.

We strongly recommend submitting corrected claims electronically to save time and money and help expedite claims processing.

Providers who submit claims through electronic data interchange (EDI) should submit corrected claims via EDI in the HIPAA-compliant 837 format.

When doing so, **please include the original claim number** in the Original Reference No. field. You can find the original claim number in the remittance advice you received for the original claim.

To submit a corrected facility or professional claim via EDI:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in **Loop 2300, CLM05-3** as one of the following:
  - **7** (corrected claim)
  - **5** (late charges)
  - **8** (void or cancel a prior claim)
- Enter the last 8 digits of the original claim number in Loop 2300, REF segment with an F8 qualifier.
  - For example, for claim #000123456789, enter **REF*F8*23456789**.◆

Reminder: QMB members exempt from Part A/B cost-sharing

The Qualified Medicare Beneficiary (QMB) program put in place by the Centers for Medicare and Medicaid Services (CMS) assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copayments. As a reminder, under the QMB program enrollees are exempt from cost-sharing liability, so all providers are prohibited from charging QMB members for Medicare cost-sharing for covered Parts A and B services.

Identifying members with QMB status

CMS's HIPAA Eligibility Transaction System (HETS) provides Medicare eligibility data to providers and their authorized billing agents (including clearinghouses and third-party vendors) to help verify a patient's QMB status and exemption from cost-sharing charges. Contact your third-party eligibility verification vendor to ask how their products reflect the new QMB information from HETS.

In addition, CarePartners of Connecticut provides the necessary information to our members and providers regarding QMB eligibility.

The Explanations of Payment we send to providers include an alert that the notice may contain claims covered by the QMB program and remind providers to review their records for any wrongfully collected cost-sharing, which may be billed to a subsequent payer.

More information

For more detailed information about CMS's QMB program, please refer to this document from the Medicare Learning Network.◆

CarePartners of Connecticut's access to care standards

One of CarePartners of Connecticut's fundamental priorities is ensuring the best possible access to care for the members we serve. To that end, the Access Standards section of our Provider Manual (*located on page 17*) outlines network practitioner standards regarding clinician availability, timeliness of appointments, and telephone accessibility, among other things. Please refer to the Provider Manual to review these standards and requirements.◆

Oral Surgery Payment Policy

We've developed an Oral Surgery Payment Policy to provide guidance on coverage, reimbursement, and coding for covered oral surgery services. There is no change to existing payment practices; the policy was developed to aid providers in documenting current reimbursement practices. For complete information, please refer to the Oral Surgery Payment Policy. ◆

Medical drug program updates

You can refer to the chart below to review changes and updates related to CarePartners of Connecticut's prior authorization and coverage program for medical drugs.

Medications being added to prior authorization		
Drug(s)	**Effective date**	**Policy & additional information**
Rytelo (imetelstat)	1/1/2025	Rytelo (imetelstat) Prior authorization will be required for Rytelo (HCPCS C9399, J3490), approved by the FDA in April 2024 for the treatment of adult patients with low- to intermediate-1 risk myelodysplastic syndromes with transfusion-dependent anemia requiring 4 or more red blood cell units over 8 weeks who have not responded to or have lost response to or are ineligible for erythropoiesis-stimulating agents.
Botulinum Toxins	2/1/2025	Botulinum Toxins
Leqvio (inclisiran)	2/1/2025	Leqvio (inclisiran)
Spravato (esketamine)	2/1/2025	Spravato (esketamine)

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Modifiers and reminders for home infusion therapy

CarePartners of Connecticut would like to remind providers who administer home infusion therapy services that when you are reporting home infusion for multiple dates of service for the same member, you should report a separate line for each date of service with the applicable procedure code(s) and number of units for that date.

In addition, effective for dates of service beginning Feb. 1, 2025, consistent with correct coding guidelines, please include modifier SH (second concurrently administered infusion therapy) or SJ (third or more concurrently administered infusion therapy) as appropriate.

For more information, refer to CareParters of Connecticut's Home Infusion Payment Policy. ◆

Helpful reminders for providers

- **Avoid Printing:** All CarePartners of Connecticut provider documentation is updated regularly. For the most current information, providers should view all documentation online at carepartnersct.com/for-providers and avoid printing.
- **Browser Note:** If you are using an outdated or unsupported browser, certain features on CarePartners of Connecticut's website may be unavailable. For an improved user experience, upgrade your browser to the latest version of Mozilla Firefox or Google Chrome.
- **Secure Provider Portal Self-Service Tools:** CarePartners of Connecticut's online self-service tools enable providers to electronically submit transactions and/or access information related to claims submission, claims status, referrals, prior authorizations, electronic remittance advice, member eligibility, panel information and more. Log in to the secure Provider portal to manage transactions online.

Not yet registered?
Information on how to register for secure access is available on CarePartners of Connecticut's public Provider website.

For more information: Public Provider Website; Secure Provider Portal

Contact information: Call Provider Services at 888-341-1508, weekdays, 8 a.m.–5 p.m.