GREY LEDGE
MEDICAL MANAGEMENT
Formerly Comprehensive Practice Management Services

MEMORANDUM

To:	***GLMM Clients***
From:	***Karen Marcoux, CPC, Sue Kandzerski, CPC, JoAnn Beahm, CPC, & Tori Morris***
Date:	***April 21, 2022***
Subject:	***Highlights from MA RI MGMA- Annual MA Payor Day Meeting***

The following information was shared by the Massachusetts insurance companies at the recent Annual MA Payor Day meeting, hosted by the MA/RI MGMA.

AllWays Health Partners – Melissa Hinckley

- New plan called Select HMO launched on 1/1/2021.
- Allies HMO launched for large groups in 2020. Allies Choice HMO for merged market launched in 2021.
- PPO Plus members will have access to the United Healthcare Options PPO network.
- For Select HMO, Value HMO and Allies HMO/Allies Choice HMO - are developing new products that will meet the customers needs for high quality, cost-effective care.
- Contact you contract manager if you have questions regarding participation in the networks.
- Eligibility screen on the Allways website will tell you if you are participating with a particular network.
- All patient ID cards have been updated in support of the No Surprise Act.
- PA and referral guidelines vary by plan – check out the attached Easy Reference Grid.
- Effective 2/1/2022 – providers not set up with EFT will begin to receive e-payment via Virtual Credit Card (VCC). VCC will be sent by secure fax or mailed with EOP. Option to opt out for Virtual Credit Card is available online, where providers may enroll in EFT. Here is the link to the landing page ***allwayshealthpartners.org*** – Payment Options.
- Allwayshealthpartners.org/providers/claims-information – See Claims Resource Page. Highlights of the Claim Resource Page include clear guidance as to where to send claims. ID card images to help identify the type of plan.
- New claim address for paper claim submission is PO BOX #323 Glen Burnie, MD 21090

- Verifying prior authorization & coverage can be done by searching by Member ID number and Code. Coverage and prior authorization requirements will display. Prior Authorization request can be done by the portal. Save time and validate prior authorization requirements before you submit a new request. If the service requires prior authorization, click on submit new request in the PA section of the Provider Portal homepage.
- Prior authorization tips:
  - ❖ Have the clinical information available. Review the patient's medical chart to assemble documented clinical indications for the requested service. If the authorization pends, you may need to upload the clinical information.
  - ❖ Answer questions based on the patient's clinical information. If the appropriate answer isn't available, select "Other clinical information" and add a comment.
  - ❖ Add Reviewer Comments at the question level to document clinical details.
  - ❖ Review notes within the criteria; they serve as a valuable resource in accurately conducting a review by explaining criteria rationale, defining medical terminology and detailing new clinical knowledge/evidence.
- Provider Enrollment – Portal gives you online access to submit the following transactions:
  - ❖ Affiliate a new doctor - Enrollment and credentialing submissions can take a minimum of 45 days to be fully processed. Review your site/practice roster prior to inquiring on a status request.
  - ❖ Status Checks – Check the status of any requested provider enrollment – Have to wait 45 days for a status check.
  - ❖ Open or closed provider panels.
  - ❖ Terminate an affiliation - AllWays Health Partners requires written notification at least 60 days prior to the practitioner's termination date unless otherwise agreed upon.
  - ❖ Demographic changes to AllWays Health Partners.
  - ❖ Validate Directory and Enrollment Information.
  - ❖ CAQH Direct Assure – Allways Health Partners is partnered with HCAS and CAQH to enable practices to validate enrollment and directory date.
- Visit provider.allwayshealthpartners.org/manage-subscription to register for the monthly Newsletters and other features.

Blue Cross Blue Shield of Massachusetts – Nathan Ferguson

- CVS Caremark will be the New Pharmacy Benefit Manager in 2023 – This change will have little impact on home members get their medication. Some medications could change tiers, which could change members cost share.
- In 2022, plans with the Blue High-Performance Network (Blue HPN) can be identified by checking benefits or eligibility. Or look for the Blue HPN in the suitcase logo on their ID card. Blue High Performance Network is a national limited network and can be paired with Exclusive Provider Organization plans. Members must choose Blue HPN in-network providers for care. Only Emergency care (hospital facility) is covered when performed by an out-of-network provider. Follow the same claims filing procedures you use today for Blue Card PPO members.

- COVID – 19 Temporary Payment Policy is still in effect and will remain in effect through March 31, 2022
- As of 4/1/2022, telehealth information will be removed from the temporary payment policy and two new, renamed telehealth payment policies will be in effect. The two new policies are Telehealth – Medical Payment Policy & Telehealth – Mental Health Payment Policy along with a list of eligible services for telehealth. Highlights of the policies include new telehealth modifiers and place of service codes. Also, payment and reimbursement information for mental health, PCP, chronic disease management and all other services.
- Improving access to Mental Health Support includes:
  - ❖ focusing on network expansion through the Child Psychiatry Incentive Program (CPIP).
  - ❖ Added psychiatric care to our national telehealth platform (Well Connection).
  - ❖ Intensified integration of mental health into value-based care contracts.
  - ❖ Continued reimbursement of mental health visits and same rate as in-person visits (beyond the COVID-19 crisis).
- There is a quarterly email to Mental Health Clinicians called Mental Health Brief.
- The Consolidated Appropriations Act of 2021 includes a wide range set of law that affect health care providers and insurer's and starts with implementation dates in 2022.
- Legislation that takes effect in 2022 includes:
  - ❖ Continuity of care.
  - ❖ Machine-readable files.
  - ❖ Provider Directory Verification.
  - ❖ Surprise billing for out-of-network providers.
- ETOOLS updated – Learn about Etools without logging in. You can get a description of all the online tools using the e Tools page without having to log in. To utilize the tools a log in is required.
- CONNECTCENTER is coming in 2022. CONNECTCENTER will offer the latest online tools to check member eligibility, benefits and claim status.
- Authorization manager should be used to enter and check authorizations.
- CONNECTCENTER will not have the functionality for authorization status.
- Authorization Manager is available 24/7. On the site you can:
  - ❖ Submit authorization request for all members, all products.
  - ❖ Search member-specific authorization requirements by code.
  - ❖ Check the status of submitted authorizations and referrals for medical & behavioral health services.
  - ❖ View authorization-related correspondence.
  - ❖ PCP providers can enter outpatient specialist referrals including fertility services and oral surgery consults.
- Provider Central Resources:
  - ❖ Authorization Manager Guide.
  - ❖ Referral Quick Tip, Fertility Services Quick Tip, instructional video of referrals.
  - ❖ Webinar recording and slides.
  - ❖ Quick tips for certain provider types.

- Medication changes that took effect on 1/1/2022:
  - ❖ Formulary changes (moving medications to non-covered status, tier changes, quality care dosing changes).
  - ❖ Pharmacy medical policy changes.
  - ❖ Medical benefit changes (applies to Medicare Advantage).
  - ❖ New offerings (6-tier benefit, 90-day retail benefit, etc.).
- Provider information changes often; please update the Provider Directory as changes occur. BCBS of MA partners with CAQH for directory accuracy using DIRECTASSURE. DIRECTASSURE allows you to review or make updates to your professional and practice information. DIRECTASSURE also shares information with multiple health plans. In 2022, Federal Law (CAA) requires all providers and health insurers to verify provider directory information every 90 days.
- Providers can submit replacement claims electronically. When to use a replacement claim
  - ❖ To change or correct:
    - o Billed amounts
    - o Diagnosis codes
    - o Modifiers
    - o Patient data (except the member ID)
    - o Procedure codes
    - o To void or retract a request
    - o When another primary insurance makes a change in processing, increasing, or decreasing payment
  - Do not use a replacement claim for:
    - ❖ Appeals
    - ❖ Changing or correcting the billing NPI
    - ❖ Date of service change
    - ❖ Subscriber ID
    - ❖ POS issue – from inpatient to outpatient or vice versa
    - ❖ Claims that are past timely filing guidelines
    - ❖ Bridged claims
    - ❖ Late charges
    - ❖ Claims related to accidental injuries
    - ❖ Claims that were part of a previous recovery or audit
- Appeals address is PO BOX 986065 Boston, MA 02298 – The address to submit appeals does not differ based on the member. BCBS of MA will not give appeal status over the phone. BCBS of MA will need at least 30 days after you submit the appeal before follow up. Appeals are worked in the order the are received. Automated Message when contacting Provider Services listing the dates of appeal that BCBS of MA is currently working on. Once the appeal has been reviewed, BCBS of MA will notify you by letter, fax or an adjusted EOB

Boston Medical Center HealthNet Plan – Patrice Inda

- BMCHP is a non-profit managed care organization committed to providing the highest quality healthcare coverage to underserved populations.
- BMCHP operates in MA and NH the following plans:
  - ❖ MassHealth (including ACO).

- ❖ MA Qualified Health Plan with includes ConnectorCare.
- ❖ MA Senior Care Options (available only in Barnstable, Bristol, Hampden, Plymouth & Suffolk).
- ❖ WellSense Health Plan.

- Find a participating Doctor, Hospital or Pharmacy by visiting the BMCHP Provider Directory at https://www.bmchp.org/utility-nav/find-a-provider
- ACO Member ID's have number sequencing according to the ACO the patient is assigned. ID starting with 2 is part of Community Alliance, ID starting with 3 is part of Mercy Alliance, ID starting with 4 is part of Signature Alliance & ID starting with 5 is part of South Coast Alliance. Member ID Numbers for MCO, QHP & SCO have a member ID starting with B for MassHealth MCO, letter C for Qualified Health Plan and # 1 for Senior Care Options.
- Member eligibility can be found at the Secure Provider Portal of www.BMCHP.org. It is suggested that member eligibility be checked on the date of service before delivering services and daily for in patient admissions.
- Eligibility for SCO members changes on the first of the month.
- BMCHP has a provider portal MyHealthNet. Some enhanced features available on the provider portal are improved claim process and streamlined authorization process. Improved Claim Process includes providers be able to submit corrected claims, appeals, COB, EOB and TPL review requests online and get reimbursed faster. Streamlined Authorization Process now allows providers to upload supporting documentation to their requests.
- The Provider Portal can also check member eligibility, check claim status, submit appeal, submit corrected claims and prior authorization submissions and status inquires. Checking claim status, appeals & corrected claims will be mandated in the future to be done only on line, so it is a good idea to become acquainted now.
- In May 2022, BMC HealthNet Plan will be rebranding and renaming to Wellsense Health Plan. More information and training will be available regarding the rebranding of BMC HealthNet Plan. Re-contracting is not required and BMC HealthNet Plan will not have changes to the remit ID, address, policies, contacts and company phone numbers.
- BMC HealthNet Plan is required to keep provider information up to date and ensure the plans online directory is kept current. Providers are expected to notify the plan of any provider changes or updates as they occur. This is including address change, Pay to address change, TAX ID# change, Group Name change, NPI change, telephone or fax # change etc.
- Provider/Termination Change Form can be emailed to: www.Provider.ProcessingCenter@BMCHP-wellsense.org
- To ensure that you are receiving the important updates and notices please be sure to keep your offices contact information up to date.
- Reach out to Provider Relations Consultant to inform of staff changes in your office. You can also reach out at Provider.Info@BMCHP-wellsense.org to request a General Contact Form.
- Make sure that provider's office takes advantage of EFT, a convenient and efficient option for claims payment. For more information on how to enroll in EFT, please call your dedicated Provider Relations Consultant or provider line at 888-566-0008
- Claims should be submitted electronically to expedite payment.

- All Senior Care Option plans BMC HealthNet Plans' Model of Care require that network providers receive annual training and attest on an annual basis. A short web-based training is available at https://www.bmchp.org/I-Am-A/Provider/Training-and-Support.
- To complete the attestation, you must have your NPI number available.
- For larger group practices, it is suggested that you reach out to your Provider Relations Consultant who can assist with coordinating the training and attestation process.
- See attached list for Who are the Plan's Clinical Vendors
- BMCHP Filing limits
  - ❖ MassHealth (including ACO) 150 days
  - ❖ ConnectorCare/QHP 90 days
  - ❖ Senior Care Options 150 days
- Changes in federal Medicaid law require all managed care entity (MCE) network providers, including BMCHP network providers, to enroll with MassHealth. This means all BMCHP network providers must have two provider contracts in place: (1) a network provider contract with [MCE/Vendor]; and (2) a provider contract with MassHealth.
- MassHealth has developed the MassHealth Nonbilling Managed Care Entity (MCE) Network-only Provider Contract for MCE network providers who do not already have a provider contract with MassHealth. This specific MassHealth provider contract does not require BMCHP network providers to render services to MassHealth fee-for-service members. Visit https://www.mass.gov/forms/submit-the-masshealth-nonbilling-managed- care-entity-network-only-providercontract to complete a MassHealth Nonbilling MCE Network-only Provider Contract under this requirement within 30 days of receiving confirmation of your BMCHP enrollmentl

Cigna – Beth Hart

- Cigna is committed to complying with applicable laws, rules and regulations, including the No Surprise Act. Cigna is actively implementing and preparing for the requirements as part of the Transparency in Coverage rule and Consolidated Appropriations Act (CAA). The initial provisions, which took effect on January 1, 2022, primarily affected non-participating providers and how Cigna reimburses out-of-network claims. Cigna continues to establish programs and tools to support providers as a result of the CAA and No Surprise Act. The rulemaking process is likely to continue as Cigna evaluates the final requirements as they are issued.
- Permanent Virtual Care Reimbursement Policy as of January 1, 2021:
  - ❖ Reimbursement remains at parity (100% of face to face)
  - ❖ Synchronous communication required (audio & video), except for audio-only codes
- Services reimbursed under the policy are Routine Check – ups, General wellness visits, New patient exams & Behavioral assessments
- Common Codes Included in the policy:
  - ❖ Outpatient E&M codes for new and established patient's (99202 – 99215)
  - ❖ Physical and occupational therapy E&M codes (97161 – 97168)
  - ❖ Telephone – only E&M codes (99441 – 99443)
  - ❖ Annual wellness visit codes (G0438 – G0439)

- Reimbursement Requirements:
  - ❖ Services must be on the list of eligible codes.
  - ❖ Claims must be submitted on a CMS-1500 form or electronic equivalent.
  - ❖ Modifier 95, GT or GQ must be appended to the virtual care code(s).
  - ❖ Must bill a typical face to face place of service (11).
  - ❖ Must use both audio & video (except for phone-only codes).
- Customer cost-share is waived for COVID – 19 diagnostic testing and related office visits through the public health emergency (PHE) period, currently set to expire on April 15, 2022.
- Cigna reimburses all emergency use authorized (EUA) vaccines and treatments.
- Cigna's expedited credentialing process is in place through April 30, 2022.
- Cigna's waiver of the facility-to-facility transfer authorization requirement is in place through March 31, 2022.
- Consistent with federal guidelines for private insurers, Cigna commercial covers up to eight over-the-counter (OTC) diagnostic COVID-19 tests per month (per enrolled individual) with no out-of-pocket costs for the tests.
- In addition to our permanent Virtual Care Reimbursement Policy, Cigna will continue to make additional virtual care accommodations until further notice by allowing the following:
  - ❖ Facilities to bill on a UB-04 claim form.
  - ❖ Providers and facilities to bill certain home health codes.
  - ❖ Code G2012 to be billed for quick 5–10-minute phone conversations.
  - ❖ Most synchronous technology to used (e.g., FaceTime, Skype & Zoom).
  - ❖ eConsult codes (99446-99449, 99451 and 99452).
  - ❖ Preventive Care Services (99381-99387 and 99391-99397).
- Additional information about updates is available on the Cigna for Health Care Professionals website (CignaforHCP.com>Cigna's response to coronavirus). Cigna's response to coronavirus includes resources of Interim billing guidelines, Frequently asked questions, Interim Telehealth Guidance & many other resources.
- As of September 1, 2021, precertification requirements for CT scans and MRI includes a medical necessity review for site of care customers with fully insured Cigna plans and participants in the Cigna employer account.
- eviCore will approve precertification requests that include an appropriate site of care and are in accordance with the terms of Cigna's coverage policy and the customers benefits. Also, an outpatient hospital setting when medically necessary, as defined in the Site of Care: High-tech Radiology policy and the customer's benefit plan.
- As of September 1, 2021, Cigna does not cover certain MRI or CT scans performed in an outpatient hospital setting if there is a less restrictive setting available, unless there is clinical rationale.
- Precertification request status: eviCore.com > PROVIDERS. High-tech Radiology Site of Care program: eviCore.com/resources/healthplan/Cigna . Precertification of high-tech radiology services – eviCore: • eviCore.com/providers or 888.693.3297 (7am – 7pm ET). Clinical guidelines: eviCore.com.
- Benefits eligibility and coverage: Cigna Customer Service at 800.88Cigna (882.4462)

- January 1, 2022, Cigna expanded prior authorization requirements for certain oncology drugs to include medical necessity review of the site of care. There will be no change in the requirement for requesting prior authorization for qualifying specialty medications. If a prior authorization request includes an outpatient hospital setting for administration of a drug, a Cigna medical director or pharmacist may contact the referring provider to discuss administration at a less intensive site of care. Cigna may also deny continued authorization of coverage if it is not medically necessary for the patient to receive services in an outpatient hospital setting. A full list of drugs subject to site of care review is included in the Medication Administration Site of Care – 1605 coverage policy. To review the coverage policy, go to the Cigna for Health Care Professionals website at CignaforHCP.com > Resources > Coverage Policies > Pharmacy (Drugs, Vaccines & Biologics) A-Z Index > Medication Administration Site of Care – 1605.
- Providers can call their Cigna representative or Cigna Customer Service at 800.882.4462 with questions.
- Coverage and reimbursement policy updates:
  - ❖ Advanced Practice Health Care Providers (R37)
  - ❖ Chiropractic Care (CPG 278)
  - ❖ Physical Therapy (CPG 135)
  - ❖ Occupational Therapy (CPG 155)
  - ❖ Facility Routine Services, Supplies & Equipment (R12)
  - ❖ Omnibus Reimbursement Policy (R24)
  - ❖ Breast Reconstruction Following Mastectomy or Lumpectomy (0178)
  - ❖ Tissue Engineered Skin Substitutes (0068)
  - ❖ Unacceptable Principal Diagnosis Codes (R38)
  - ❖ Facility Routine Services, Supplies & Equipment (R12)
- Review all Cigna coverage policy updates at CignaforHCP.com > Review Coverage Policies.
- Beginning April 1, 2022, patients with Cigna Pharmacy coverage who fill prescriptions for drugs that are no longer on the formulary may experience higher out of pocket cost.
- To obtain a list of the affected drugs or to search for alternative medications for your patients, please refer to the resources listed below:
  - ❖ Prescription Drug List changes for 2022 - Go to the Cigna for Health Care Professionals website (CignaforHCP.com) > Get questions answered: Resource > Pharmacy Resources > Cigna's Prescription Drug Lists: View Documents.
  - ❖ Customer specific drug coverage search tool - Log in to CignaforHCP.com. Then, perform a patient search by name, ID number, or date of birth. You must be a registered user of the website to access this tool.
- Effective January 1, 2022, Cigna requires precertification for several gastroenterology procedures including: Esophagoscopy/Esophagogastroduodenoscopy (EGD) for most Cigna commercial members (Non – Medicare)
- The following resources are available to help determine benefits and eligibility for patients with Cigna coverage:
  - ❖ Cigna Customer Service – 800.882.4462

- ❖ Cigna for Health Care Professionals website – CignaforHCP.com > Patient's (login required).
- ❖ eviCore provider portal – eviCore.com > Eligibility Lookup (login required).
- ❖ eviCore Intake Team – 866.668.9250

- Additional program resources:
  - ❖ Gastroenterology program website - https://www.evicore.com/resources/healthplan/cigna.
  - ❖ Physician worksheets – www.eviCore.com/resources/healthplan/Cigna > Solutions Resources > Gastroenterology > RESOURCES > Cigna Clinical Guidelines & Online Worksheets.
  - ❖ Request precertification of endoscopy and EGD procedures – eviCore.com or 888.693.3297.
- In September 2021, Cigna Behavioral Health changed its name to Evernorth Behavioral Health. For providers who have Cigna behavioral and medical contracts, this name change only applies to the behavioral network. Contractual obligations remain the same under Evernorth. Use Provider.Evernorth.com, the new behavioral provider website, to look up patient information and other transactional activities.
- Claim reconsiderations, appeals and viewing precertification can be done online @ CignaforHCP.com
- Cigna does credential PA's.

Fallon Health – Marybeth Curnen?

- Fallon Health offers individual or staff education sessions during or after regular business hours.
- Provider Services Department
  - ❖ 866 – 275 -3247, option 4
- Fallon began transitioning membership off of the commercial plans last July.
- Commercial lines of business will be in effect through December 2022; membership in Direct Care, Select Care, Steward Community Care and Fallon Preferred Care will be reduced and phased out as employer groups reach their anniversary date.
- Contract renewals are being managed to address the timeline mentioned above.
- NaviCare 2022 Plan has two new plan options
  - ❖ Medicare Advantage HMO Special Needs Plan (SNP)
  - ❖ Senior Care Options (SCO) program
- In early March 2022, Fallon Health transitioned from ClaimCheck to ClaimsXten for claim review software. ClaimsXten will allow Fallon Health to utilize regulatory and industry standard claims management with the ability to reference historical claims data and efficiently bundle and pay eligible claims. ClaimsXten will also assist in adjudicating claims in a manner that is organized, cost effective and follows applicable regulatory requirements pertaining to coverage and benefits.
- OptumRx is the new Pharmacy Benefits Manager (PBM) effective January 1, 2022.
- All Fallon members received new ID cars with the updated PBM information.

- Active prior authorizations were transferred from CVS Caremark to OptumRX automatically.
- OptumRX Home Delivery – Prescriptions with available refills have transitioned to OptumRX automatically, with the exception of controlled substances.
- There are three options for prescribing with OptumRX Home Delivery:
  - ePrescribe – Add the OptumRx profile in your electronic medical record (EMR) system using the following information: OptumRx Mail Service 2858 Loker Ave. East, Suite 100 Carlsbad, CA 92010.
  - Call an OptumRx pharmacist at 1-800-791-7658.
  - Fax (for prescription submissions only – no PAs): 1-877-342-4596.
- COVID – 19 Resources:
  - Provider Frequently Asked Questions (FAQ) can be found on our website at: http://www.fchp.org/en/providers.aspx.
  - Payment policies related to COVID – 19 can be found on the website at http://www.fchp.org/providers/criteria-policies-guidelines/payment-policies.aspx.
- Fallon Health began covering over-the-counter COVID – 19 tests whose plan includes a pharmacy benefits as of January 15, 2022. Members can present their ID card at any network pharmacy to obtain an at home test. Members can get up to 8 individual tests per month. Dependent on product line, members can submit for reimbursement for tests paid out of pocket. For more information see the website: https://www.fchp.org/covid-tests.aspx. Fallon Health covers medically necessary PCR and antigen tests at no cost when ordered by a physician.
- Currently specimen collection for Medicaid and Navicare is separately reimbursed in accordance with Medicaid guidance through 3/31/2022
- Fallon will continue to waive all members cost sharing for COVID – 19 related medically necessary telehealth services only, until further notice. For non-COVID related telehealth visits, member cost-sharing will apply. Report telehealth services with a POS 10 as applicable and note the revised description of POS 02.
- When a Preventive Medicine Service has been delivered via telehealth and reimbursed by Fallon Health:
  - For NaviCare members, Fallon will reimburse one in-person follow-up Evaluation & Management (E/M) Service to complete the components of the Preventive Medicine Service not performed on the day of the Preventive Medicine Service. The follow-up E/M Service can be billed with CPT code 99211, 99212 or 99213, depending on the complexity of the visit. Additional services, such as immunization administration and visual acuity screening, may be reported in addition to the E/M Service.
  - For Commercial and Fallon Medicare Plus members: Fallon will not reimburse an additional Preventive Medicine Service or E/M Service to complete components of the Preventive Medicine Service not performed via telehealth. Immunization administration and visual acuity screening will be reimbursed.
- For more specifics, please refer to our Telemedicine payment policy at http://www.fchp.org/providers/criteria-policies-guidelines/payment-policies.aspx
- Vaccine & Monoclonal Antibody Administration:
  - For Fallon Medicare Care Plus, Fallon Medicare Care Plus Central, Fallon Navicare SNP, and Summit Elder Care • Effective January 1, 2022,

Providers will bill Fallon Health directly for the administration (no longer bill the CMS Medicare Administrative Contractor).
    - For Fallon 365 Care, Berkshire Fallon Health Collaborative, Wellforce Care Plan, Navicare SCO • Providers submit a claim to Fallon Health for the vaccine administration with an accompanying claim line for the vaccine with an SL modifier and a charge of $0.00.
    - For Commercial members • Providers should submit a claim to Fallon Health for the vaccine administration.
- Sequestration - CMS extended the suspension of the payment reduction through March 31, 2022. Fallon Health will implement the reduction on Fallon Medicare Plus and Fallon Medicare Plus Central applicable payments as follows:
    - Effective 4/1/22-6/30/22 a 1% reduction
    - Effective 7/1/22 a 2% reduction
- When the Federal Public Health Emergency comes to an end, Fallon will begin arrangements to resume the need for a PCP referral submission into ProAuth for the products listed below:
    - Fallon Medicare Plus
    - Fallon Medicare Plus Central
    - NaviCare
    - Fallon 365 Care
    - Berkshire Fallon Health Collaborative
- In preparation for the end of the PHE, please make sure your ProAuth log in is still active. The ProAuth tool is for providers to enter referrals, prior authorization and submit clinical documentation in lieu of the Standardized Request for Authorization Form. ProAuth can also be used to track the status of your referral or prior authorization request. Please see the ProAuth FAQ link guidance at https://www.fchp.org/en/providers/resources/proauth-help.aspx. Fallon Health requires all PCP referrals and Prior Authorizations request (with supporting documentation) to be submitted via ProAuth. ProAuth access enrollment requests for new users can be filled out and submitted online at: https://www.fchp.org/providertools/ProAuthRegistration or by completing the ProAuth Enrollment form and email that to AskFCHP@fallonhealth.org or sent by fax to (508) 368-9902. ProAuth training can be found http://www.fchp.org/en/providers.aspx.
- No Surprises Act and Massachusetts Chapter 260 of the Acts supports no balance billing to a member for expenses related to out-of-network emergency facility and professional services, out-of-network services delivered in an in network facility, unless notice and consent provided, and all air ambulance transport services. The No Surprises Act applies only to commercial members enrolled in plans that are new or renewed as of January 1, 2022. For Fallon Health, this means that Community Care members will be the only members impacted. Fallon will begin implementing the changes associated with out of network reimbursement at the qualified payment amounts (QPA) in a phased approach in quarter 2. The No Surprises Act also includes a requirement for the Health Plans to verify provider information every 90 days and for providers to validate this information. This is done though the CAQH Proview, DirectAssure system. https://www.hcasma.org/Directory.htm.

- Fallon sends an Electronic quarterly newsletter. To sign up for the newsletter send your email address to askfchp@fallonhealth.org. The newsletter will be your notification of important changes to look for including Updates, New Information, Policies and additional information.
- Fallon Health contact information:
  - Fallon Provider Relations | 1-866-275-3247
  - Prompt 1 | Customer Service (to determine member eligibility or benefit information)
  - Prompt 2 | Claims
  - Prompt 3 | Referrals, Prior Authorizations or Case Management
  - Prompt 4 | Provider Relations
  - Prompt 5 | Pharmacy Services
  - Prompt 6 | EDI Coordinators and ProAuth Support
- Fallon Health business partners:
  - American Specialty Health (ASH) 1-800-972-4226
  - Beacon Health Options 1-781-994-7556
  - Care Centrix (CCX) 1-866-827-2469
  - Dental Benefit Providers (DBP) 1-800-822-5353
  - EyeMed Vision Care 1-800-521-3605
  - eviCore 1-888-693-3211
  - HealthCare Administrative Solutions, Inc (HCAS) 1-617-246-6451
  - Multiplan/PHCS 1-866-416-6489
  - Optum Rx 1-800-791-7658
  - Rx Savings Solutions 1-800-268-4476
  - Zelis 1-866-489-9444

Health New England – Mary Santiago & Mary Humel

- Public Site: http://healthnewengland.org/provider.
- Tools and Resources page will give you Coding Best Practices & Tips, Resources, Contact Information, Provider Manual & Behavioral Health.
- ProviderMatters allows providers to receive an email notification when important information is added. Examples include:
  - New Products and Services
  - HNE/Industry News and Information
  - Notice of Policy Changes
  - Pharmacy Updates
  - Policy/Admistrative Reminders
  - Semi-Annual Notice of Benefit Changes
- Prior Authorization guidelines for procedures and services requiring prior authorization can be found in the Provider Manual.
- To verify a specific service, procedure, or treatment requiring prior authorization, contact Health Services directly at (413) 787-4000, ext. 5027 or (800) 842-4464, ext. 5027. Form for prior authorization can be located at http://healthnewengland.org/forms.
- Health New England follows CMS rules when services rendered are related to Telehealth.
- See Key Contacts attachment

MassHealth – Marilyn Thurston

- MassHealth is excited to introduce enhancements to the Provider LMS for Non-OLTSS providers.
- The Provider LMS delivers:
    - ❖ Previous live training presentations
    - ❖ New on demand training courses
    - ❖ Resources
    - ❖ Course surveys
- Users that were enrolled in the previous version of the LMS were sent an e-mail notification in October and November announcing the change and providing important login information. New Users can create a profile and begin using the system immediately. Visit: https://masshealth.inquisiqlms.com/Default.aspx.
- It is recommended that providers take the Introduction to Inquisiq course as an introduction to the system upon initial login.
- Courses include (Trainings will be added regularly):
    - ❖ Claim Denial Reasons and Resolution – including 1945 edit
    - ❖ Denied Claim Correction via Direct Data Entry
    - ❖ Customer Web Portal (PT-1)
- Provider feedback is important for each training – Surveys provide valuable information that helps MA Health continually improve your experience. Visit: https://masshealth.inquisiqlms.com/Default.aspx.
- MassHealth will reimburse providers delivering any telehealth-eligible covered service via any telehealth modality at parity with its in-person counterpart; and an eligible distant site provider delivering covered services via telehealth in accordance with this updated policy may bill MassHealth a facility fee if such a fee is permitted under such provider's governing regulations or contracts. Providers must include the place of service (POS) code 02 when submitting a professional claim and modifier GT when submitting a facility claim for services delivered via telehealth.
- Additionally, for any such professional claim providers must include:
    - ❖ Modifier 95 to indicate services rendered via audio-video telehealth
    - ❖ Modifier V3 to indicate services rendered via audio-only telehealth and/or
    - ❖ Modifier GQ to indicate services rendered via asynchronous telehealth
- MassHealth will initially implement these modifiers through a six-month informational edit period. Effective on or after April 11, 2022, MassHealth will discontinue this informational edit and will deny claims containing POS code 02 that are missing one of these modifiers.
- MassHealth is part of the CMS PERM audit for RY 2023. The PERM audit measures improper payments in Medicaid and CHIP and produces improper payment rates for each program. The review will consist of claims data for the time period of July 1, 2021 - June 30, 2022.
- Contractors:
    - ❖ The Lewin Group is the Statistical Contractor (SC)
    - ❖ NCI Information Systems Inc. is the Review Contractor (RC)
- Providers will receive a request letter from the RC (NCI) and will have 75 calendar days from the date of the request letter to submit the record. Providers may send documentation by fax, by mail or if using a Health Information Handler (HIH), by CMS' electronic submission of medical documentation (esMD) system. Reminder

calls and letters are made after 30, 45, and 60 days (unless received). Non-response letters are sent on day 75 via registered mail. If submitted documentation is incomplete, the RC sends an additional documentation request (ADR) letter giving the provider 14 days to submit additional documentation. A reminder call is made, and a letter is sent if pending after 7 days. If the RC receives records of poor quality or with other issues, the RC sends a Resubmission Letter detailing the issue and asking the provider to resubmit the information.

- Frequent Mistakes for Providers to avoid:
  - ❖ Not responding within required timeframes
  - ❖ Submitting records for the wrong patient
  - ❖ Submitting records for the right patient but for the wrong date of service
  - ❖ Not submitting legible records – e.g., colored backgrounds on faxed documents
  - ❖ Not copying both sides of two-sided pages
  - ❖ Marking/highlighting that obscures important facts when copied or faxed
- States must screen, enroll, and periodically revalidate all Managed Care Entity (MCE) network providers. MassHealth has delegated the screening, enrollment and revalidation of the MCE provider networks to the MCEs. Screening includes all federally required disclosures, verifications of federal exclusions, NPI, Social Security Administration (SSA) Death Master File (DMF) and license information as applicable.
- States must enroll providers that are not already actively enrolled with MassHealth (Fee-for-Service (FFS) and Ordering, Referring & Prescribing (ORP)
  - ❖ Where the MCE has a different NPI, address, TIN or Provider Type (PT) from MassHealth a contract/enrollment are required
- An MCE-only provider must have a signed MassHealth Nonbilling Managed Care Entity (MCE) Network-only Provider Contract
  - ❖ For entities one contract is needed for each NPI/TIN/ PT combination
  - ❖ If the provider has an existing MassHealth relationship that is different than the MCE, a contract is needed for the MCE relationships
  - ❖ The MCE will identify providers who require a contract/enrollment
- An MCE only (not enrolled with MassHealth but enrolled with one or more MCEs) provider is not required to render fee-for-service care. Validating MCE networks against the MassHealth network (Validation is based on NPI/TIN/PT/Address). Plans are outreaching to providers who must complete a MassHealth Nonbilling Managed Care Entity Network-only Provider contract. MCEs are submitting enrollment files for MCE only providers. Providers are only required to submit a contract. If a provider is disputing the requirement to sign a contract and the information the MCE is maintaining they must contact the MCE. If a provider is disputing the information MassHealth is maintaining, they must contact their respective MassHealth customer service vendor. If the MCE submits enrollments for only providers not known to MassHealth (FFS/ORP) this should not impact your MassHealth relationship and billing.
- On March 21, 2022, MassHealth updated its Eligibility Verification System (EVS) available on the Provider Online Service Center (POSC) and the HIPAA Health Care Eligibility Benefit Inquiry and Response (270/271) transaction to include the additional benefit plans:
  - ❖ CMSP

- ❖ Limited
- ❖ HSN

- Trading partners should visit the MassHealth HIPAA Companion Guides webpage listed below to evaluate the changes outlined in the MassHealth HIPAA Health Care Eligibility Benefit Inquiry and Response (270/271) Companion Guide, and ensure that their systems can accept the additional benefit plan information @ https://www.mass.gov/lists/masshealth-hipaa-companion-guides. Providers, Trading Partners, and Relationship Entities must not share MassHealth User IDs and passwords used to access MassHealth systems with anyone.
- Each user attests to the Virtual Gateway (VG) Terms and Conditions upon initial sign-on to any VG hosted application (e.g., POSC). All MassHealth providers, trading partners and relationship entities that have been assigned a User ID and Password to access the Provider Online Service Center (POSC) and MassHealth connectivity methods (e.g., IVR, point to point) are solely responsible for the use of that user ID and must NOT share it with any other individual. Sharing user IDs is a violation of the policy. Every user within an organization that accesses the POSC or MassHealth connectivity methods must be assigned their own user ID. MassHealth monitors shared user ID activity on a regular basis. The user ID of any user that violates the VG Terms and Conditions may be subject to termination. Each organization must be sure that access to the POSC is accurately maintained to ensure that only those persons that should have access to the organization's data can view, submit, or receive information on behalf of the organization
- The Primary User within an organization who is responsible for managing user access to the organization's information on the POSC and MassHealth connectivity methods must, at a minimum, do the following:
  - ❖ Ensure that a back-up administrator has been assigned to support user. access requests in the Primary User's absence.
  - ❖ Ensure that each user has been issued their own user ID.
  - ❖ Terminate user IDs once a staff person has left the organization and once affiliate and vendor relationships and engagements have ended.
  - ❖ Establish and maintain a quarterly, semi-annual, or annual review and alignment of all user access to safeguard the organization's MassHealth related information.
- Any questions about the MassHealth User ID policy, please contact MassHealth Customer Service Center at 800-841-2900 or MassHealth LTSS Provider Service Center at 844-368-5184. DO NOT contact the Virtual Gateway.
- For additional information you may refer to mass.gov for Provider Security job aids at https://www.mass.gov/service-details/job-aids-for-the-provider-online-service-center-posc.
- Specific job aids may be found at the links below:
  - ❖ How to link a subordinate user (already has a VG user ID) to a provider PIDSL: https://www.mass.gov/doc/new-mmis-job-aid-link-subordinate-accounts/download.
  - ❖ How to update the password for a user: https://www.mass.gov/doc/new-mmis-job-aid-change-password/download (Primary user should update the passwords for subordinate users).

- ❖ How to create a subordinate user (someone that does not already have a VG user ID): https://www.mass.gov/doc/new-mmis-job-aid-create-subordinate-accounts/download.
- ❖ How to update subordinate user information: https://www.mass.gov/doc/new-mmis-job-aid-update-accounts/download

- Section 6401 of the Affordable Care Act established a requirement for Medicare and Medicaid to revalidate enrollment information for all enrolled providers, regardless of provider type, under new enrollment screening criteria at least every 5 years. MassHealth began implementation of this requirement in March 2014.
- In response to the COVID-19 Public Health Emergency, MassHealth temporarily suspended the revalidation process. Beginning January 2022, MassHealth resumed revalidation of provider enrollments. The first wave of providers that need to revalidate include approximately 2,000 providers, including both those who are scheduled to revalidate each month as well as providers who were not revalidated during the Public Health Emergency. Failure to complete revalidation in a timely fashion can result in sanctions. Sanctions may include, but are not limited to, administrative fines and suspension or termination from participation in MassHealth. MassHealth will mail a letter to providers who need to revalidate. The letter will include the revalidation requirements and the documents that need to be submitted as part of the revalidation process. Providers will have 45 days from the date of the revalidation letter to complete the revalidation process. Providers will be required to do a self-attestation on the Provider Online Service Center (POSC) if the provider is not enrolled in Medicare. Providers who are enrolled with Medicare would only be required to submit an updated Federally Required Disclosure Form, which can also be submitted via the POSC. For more information, visit the MassHealth Provider Revalidation Page on Mass.gov, or contact MassHealth Provider Enrollment & Credentialing at revalidation@mahealth.net.
- As previously released in MassHealth Transportation Bulletin 19, effective April 1, 2022, all wheelchair van services currently covered by MassHealth as fee-for-service transportation will be provided as brokered transportation through Human Service Transportation (HST) Office selective contracts with transportation brokers.
- As of April 1, a PT-1 will need to be submitted via the CWP, in place of the current Medical Necessity Form, for MassHealth members to receive wheelchair van transportation as part of safe discharge planning.
- The Customer Web Portal (CWP) is the web-based self-service system used by MassHealth providers to submit Provider Requests for Transportation Services (PT-1s). The CWP can be used to request brokered, non-emergency transportation for MassHealth members.
- Enhancements to the CWP will be implemented by MassHealth on April 1st ,2022 which include
  - ❖ PT-1 request changes (including updates to accommodate hospital discharge requests and submissions from nursing facilities)
  - ❖ New PT-1 modification features
  - ❖ New PT-1 status notification features
  - ❖ Member CWP access to view PT-1 status
- MassHealth bulletins are all available on http://www.mass.gov/masshealth-provider-bulletins.

- MassHealth for providers web page is available at: https://www.mass.gov/masshealth-for-providers
- Sign up to receive email alerts when MassHealth issues new bulletins and transmittal letters, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

Medicare – Lori Langevin

- During the COVID-19 Public Health Emergency, information and instructions may change and will turn to prior instructions following the PHE.
- It is vital to ensure that you receive the latest information as soon as it becomes available. Please take the following steps to ensure you have access to the latest updates which includes:
  - ❖ Sign up for listserv messaging from both • CMS Listserv and • National Government Services Email Updates
- Routinely check the CMS Current Emergencies webpage and NGS COVID-19 News page (CMS.gov).
- Modifier CR (catastrophe/disaster related) can be used on professional and outpatient institutional claims. CR modifier is not required on telehealth services. CS modifier waives cost sharing requirements. DOS on/after 3/18/2020 - Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits. Append CS modifier to EM service performed, when E/M service leads to COVID-19 testing. This will allow the E/M to be paid at 100% of the fee schedule.
- List of Telehealth Services can be found on the CMS.GOV website.
- Services originally added to the Medicare telehealth services list as a result of the PHE will be retained on a temporary Category 3 basis until the end of CY 2023. This will allow stakeholders to analyze and consider permanent addition of these services.
- 2 additional modifiers for CY 2022 relating to telehealth mental health services
  - ❖ FQ - A telehealth service was furnished using real-time audio-only communication technology
  - ❖ FR - A supervising practitioner was present through a real-time two-way, audio/video communication technology
- After the PHE, mental health services will continue to be permissible with the patient's home as the originating site. The mental health practitioner furnishing such telehealth services must have furnished both including an in-person, non-telehealth service to the beneficiary within the six-month period before the date of service of a telehealth service and an in-person, non-telehealth service to the beneficiary must occur at 12-month intervals for subsequent care (The practitioner must document any valid exception to this rule in the medical record).
- The pre and post F2F visit for telehealth mental health services may be performed by a clinician's same-specialty, same-group colleague if the original practitioner is unavailable.
- Telehealth mental health services must be furnished via interactive telecommunication that includes both audio and visual two-way, real-time communication, with two exceptions described below:
  - ❖ Two exceptions to audio-visual technology rule have been made for mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where (1) Beneficiary is not

capable of two-way audio/video technology (2) Beneficiary does not consent to the use of two-way, audio/video technology

- POS code 02 has a revised description of Telehealth provided other than in patient's home. Also, the addition of new POS code 10 (Telehealth provided in patient's home). Medicare hasn't identified a need for new POS code 10.
- On/after 3/1/2020 and for duration of PHE, Medicare will allow providers to bill audio or audio/video telehealth service with modifier 95 (professional telehealth service from a distant site). Payment would be equal to what it would have been (if were performed FTF) in the absence of a PHE.
- Telehealth services are professional services billed as distant site.
- Same as any face-to-face patient encounter, except a statement needed indicating service was telehealth, along with, patient location, provider location, names of all persons participating in the telemedicine service and their role in the encounter.
- For time-based services, document start/stop time or total time.
- Teaching physician may use audio/video telecommunications during key portions of service.
- CMS is making a number of refinements to current policies for:
  - Split (or shared) E/M visits
  - Critical care services
  - Physician Assistant (PA) Services
  - Therapy Services
  - Reference: 2022 Medicare Physician Fee Schedule Final Rule
- In the CY 2022 PFS final rule, CMS is establishing the following:
  - Definition of split (or shared) E/M visits as E/M visits provided in the facility setting by a physician and an NPP in the same group
  - The visit is billed by the physician or practitioner who provides the substantive portion of the visit
  - Effective 1/1/2022, Modifier FS required on all E/M services that have been performed on a split/shared basis (Modifier FS applies to split/shared E/M service codes used in the inpatient and outpatient facility setting)
- For CY 2022 - The substantive portion can be history, physical exam, medical decision-making, or more than half of the total time (When using time to assess the substantive portion of the service, the provider who spent and documented the most time is considered the billing provider).
- For CY 2023 - The substantive portion of the visit will be defined only as more than half of the total time spent (When using time to assess the substantive portion of the service, the provider who spent and documented the most time is considered the billing provider).
- Split/shared rules in the facility setting (inpatient and outpatient) apply to:
  - New and established care for outpatients and for initial and subsequent care for inpatients
  - Observation services
  - Prolonged services
  - Consultative services
  - Admission and discharge services
  - Critical care services
  - Emergency Department services

- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record. Each provider must document his/her contribution to the service and, if applicable, the specific time that he/she spent on the service.
- Observation occurs in an outpatient facility setting. Observation codes (99218-99220, 99224- 99226) are used only by the primary physician who is responsible for care. During the observation period, consultative providers bill services using outpatient codes 99202-99205 and 99211-99215. Attending physicians and consultants may perform split/shared services in the observation setting. For CY 2022: split/shared observation services may be level-set based on service components (history, exam, MDM) or on cumulative time spent by both providers. For CY 2023: split/shared observation services will be level-set based on cumulative time only.
- Critical care includes multiple other services that are not separately payable (These services are defined in the AMA 2022 CPT Manual, referenced in the CMS 2022 Final Rule). When medically necessary, critical care may be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty. Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty. The practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care. Both services are medically necessary and are separate and distinct, with no duplicative elements from the critical care service provided later in the day. Practitioners must report modifier 25 on the claim when reporting these critical care services. As of 1/1/2022, critical care services may be furnished as split (or shared) visits. Physician and NPP members of the same group may split/share critical care service over a full DOS. Service may be billed based only on cumulative time spent by both providers. Substantive (billing) provider = spent and documented >50% total time. Critical care by the performing surgeon may be payable in the global period, only when it is unrelated to the surgery. Modifier FT should be appended to claims for critical care in the global period by the performing surgeon, for a clinical situation unrelated to the surgery.
- As of 1/1/2022, PAs may bill the Medicare program and be paid directly for their services in the same way that NPs and CNSs currently do. As of 1/1/2022, PAs may reassign their rights to payment for their services, and may choose to incorporate as a group comprised solely of practitioners in their specialty and bill the Medicare program, in the same way that NPs and CNSs may do. PAs now planning to bill directly to Medicare must update their enrollment status including practice ownership details, practice address, medical record correspondence address, billing agency details if applicable.
- New modifiers CQ and CO - Identify and make payment at 85 percent of the otherwise applicable Part B payment amount for physical therapy and occupational therapy services furnished in whole or in part by PTAs and OTAs when they are appropriately supervised by a PT or OT, respectively for dates of service on and after 1/1/2022. CMS' revised policy would allow a 15-minute timed service to be billed without the CQ/CO modifier in cases when a PTA/OTA participates in providing care to a patient, independent from the PT/OT, but the PT/OT meets the Medicare billing requirements for the timed service on their own, without the

minutes furnished by the PTA/OTA, by providing more than the 15-minute midpoint (That is, eight minutes or more also known as the eight-minute rule).
- NGSConnex portal went live on February 28, 2022.
- The new secure, online provider portal will offer a modern look and feel, consistent, streamlined and intuitive navigation and the same valuable inquiry and transaction information you have available and rely on today.
- See JK Contact Information page attached.

Point32Health – Heather Lawson
(Harvard Pilgrim HealthCare – Tufts Health Plan)

- Harvard Pilgrim Health Care and Tufts Health Plan Have Combined. The name of the parent organization is Point32Health. Inspired by the 32 points on a compass, Point32Health represents the role the organization plays in helping people find their version of healthier living through a broad range of health plans and tools that make navigating health and wellbeing easier. While Point32Health is the name of the parent organization, the Harvard Pilgrim Health Care and Tufts Health Plan brands will continue to appear in the marketplace and continue to follow the existing processes for each heritage brand.
- HPHC & Tufts Health Plan are currently reviewing their payment policies to assess opportunities for consistency.
- Visit the provider websites for more information and answers to frequently asked questions about the combination at:
  - https://www.harvardpilgrim.org/provider/combination-information-for-providers
  - https://tuftshealthplan.com/documents/providers/general/combination-faqs
- Point32Health Foundation is working with communities in Connecticut, Maine, Massachusetts, New Hampshire and Rhode Island to support, advocate and advance healthier lives for everyone.
- Learn more at point32healthfoundation.org.
- Harvard Pilgrim Health Care's Wellesley, MA and Tufts Health Plan's Watertown, MA locations have closed. Correspondence that was previously mailed to these locations should now be directed to the Canton address. Harvard Pilgrim Health Care's paper claims submission addresses remain unchanged. Tufts Health Plan's P.O. Box numbers have changed (There are no changes to the claims mailing address for Tufts Health Public Plans).
- Mail forwarding will be available until December 1, 2022 to give providers time to make updates to their systems.
- It is strongly encouraged to use electronic claim submission for faster processing.
- The Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) updated the ICD-10-CM code set with 11 new diagnosis codes describing SDoH. The new Z codes provide additional information regarding SDoH data such as housing, food insecurity, or transportation. Providers are encouraged to use the specialized SDoH ICD-10 codes whenever possible, as they help to provide a more complete picture of the patient. Addressing a member's health related social needs can lead to better health outcomes and lower health care costs (See Appendix attached of full list of Z Codes and Sub-codes).

- Supported Web Browsers are Firefox, Chrome & Microsoft Edge (Harvard Pilgrim Health Care and Tufts Health Plan websites are no longer supported by Internet Explorer. Internet Explorer will be retired by Microsoft in June 2022.).
- COVID-19 Information and Resources for Harvard Pilgrim Health Care can be found at https://www.harvardpilgrim.org/provider/news-center/covid-19-information-and-resources/.
- Subscribe to Network Matters at harvardpilgrim.org/providers/news-center/network-matters.
- As of January 1, 2022, Harvard Pilgrim Health Care no longer offers Stride Medicare Advantage plans in Massachusetts and Maine. Massachusetts Stride members had the opportunity to enroll in Tufts Medicare Preferred HMO, which earned 5 out of 5 stars from the Centers for Medicare and Medicaid Services (CMS) for an unprecedented 7th year in a row. Notification to our Maine Stride members included information on plan options available to them during the Medicare Advantage Annual Enrollment Period. Harvard Pilgrim will continue to offer Stride Medicare Advantage in New Hampshire. Stride members may seek care from New Hampshire, Massachusetts and Maine providers. While Stride is no longer offered in Massachusetts and Maine, our commitment to these markets is strong and we will continue to offer commercial and Medicare supplement plans in Maine and Massachusetts.
- On a quarterly basis, providers should review and verify the accuracy of their demographic data displayed in the Provider Directory. Any changes to data should be reported via the CAQH ProView® tool for those who have implemented it. If your practice has not yet implemented CAQH ProView, please submit a Provider Change Form to Harvard Pilgrim Health Care's Provider Processing Center by email at PPC@point32health.org to report changes to demographic data, panel status for each individual provider, institutional affiliations, phone number, and other practice data. For more information, please view the Directory Information news article published in the recent issue of Network Matters.
- The appearance of member ID cards will vary based on the member's product and employer group. View the Harvard Pilgrim Health Care Member ID Card Guide for details about the information that can be found on member ID cards.
- Visit HPHConnect to verify eligibility and benefit information.
- Updates to telehealth place of service (POS) coding are intended to better meet overall industry needs through greater specificity. Use POS 02 to report telehealth services rendered in a location other than the patient's home, use POS 10 to report telehealth services rendered in the patient's home. For correct coding, please report all telemedicine/telehealth claims with either POS 02 or POS 10, depending on the setting in which the visit was conducted.
- CMS has developed the following new modifiers, which are now available:
  - ❖ FQ – The service was furnished using audio-only communication technology
  - ❖ FR – The supervising practitioner was present through two-way, audio/video communication technology
- To promote further specificity and an accurate picture of the telehealth encounter, you can supplement POS 02 or POS 10 with the appropriate modifier

- You can access the Interim Telemedicine/Telehealth Payment Policy from the COVID-19 Informational Page or the Payment Policy page at the Harvard Pilgrim website at harvardpilgrim.org/provider.
- The public provider website offers features including:
  - ❖ Clean, easy-to-navigate design.
  - ❖ Filtering and search functionality.
  - ❖ Intuitive navigability.
  - ❖ Centralized information at your fingertips, including: – Payment Policies – Medical Policies – Provider Manual – Network Matters.
- The secure provider website, HPHConnect, offers features including:
  - ❖ Quick access to the transactions you use the most.
  - ❖ Centralized resources.
  - ❖ Smooth search capabilities and time saving templates.
  - ❖ Increased usability.
  - ❖ Easy access to information.
  - ❖ PCP changes.
- To ensure that your account remains active and that you can continue to access HPHConnect's convenient electronic tools and transactions, it is recommended to log in regularly.
- Accounts that have not been logged into for over 120 days are routinely frozen, requiring the user to contact Harvard Pilgrim Health Care's eBusiness team to unlock the account.
- Any non-administrative user account that has been inactive for over one or two years (depending on the type of user) is removed from the system. The user will need to re-register or contact an administrator to regain access.
- Provider training and events can be found at: https://www.harvardpilgrim.org/provider/resource-center/provider-trainings-and-events/
  - ❖ Register for upcoming webinars and events.
  - ❖ View recordings of recent meetings and events in case you missed them.
  - ❖ Access a collection of short training videos for common transactions.
- See Provider Contact Information page attached.
- Register to receive Provider Update by Email for Tuft's Health Plan at tuftshealthplan.com/provider.
- The Coronavirus (COVID-19) Updates for Providers page contains the most up-to-date information about Tufts Health Plan's policies and coverage pertaining to COVID-19. Please visit the page regularly.
- Telehealth Services Billing for Tufts Health Together, Tufts Health Unify &Tufts Health Plan SCO for dates of service on and after April 1, 2022 will deny telehealth claims that are inappropriately billed for services that are considered ineligible for delivery via any telehealth modality. Additionally, the following coding requirements also apply:
  - ❖ Providers must include modifier GT when submitting a facility claim for services provided via telehealth.
  - ❖ Providers must use Place of Service (POS) 02 or POS 10 when submitting a professional claim for services provided via telehealth and must append the appropriate modifier to indicate the type of modality.

- For dates of service beginning April 16, 2022, professional telehealth claims that are missing one of the following modifiers will be denied:
  - ❖ Modifier 95 to indicate services rendered via audio-video telehealth
  - ❖ Modifier V3 to indicate services rendered via audio-only telehealth –
  - ❖ Modifier GQ to indicate services rendered via asynchronous telehealth
- For more information, please refer to the Temporary COVID-19 Telehealth Payment Policy.
- Medical Record Review Program Beginning in May 2022 for Tufts Health Plan Commercial Plans and Tufts Health Public Plans.
- Tufts Health has contracted with Optum to perform prospective and retrospective review of processed claims with the purpose of ensuring that claims, from January 1, 2021 forward, are accurately billed, coded, and documented appropriately given the extent and nature of the services rendered for the patient's condition, and correctly paid. Providers may receive a letter from Optum identifying one or more claims for which Tufts Health Plan is requesting medical record information. The letter will provide instructions on how to submit the requested medical records.
- Timely Follow-Up is critical after Behavioral Health Discharge. Patients hospitalized for behavioral health issues are vulnerable after discharge. Follow-up care by trained behavioral health clinicians and coordination of care between primary care physicians (PCPs) and behavioral health practitioners is critical for the patient's health and well-being. Follow-up for members hospitalized for behavioral health reasons should occur within 7 days of discharge (but not on the same day as discharge) and again within 30 days of discharge. View the Timely Follow-Up Critical After Behavioral Health Discharge article in the March 2022 issue of Provider Update for more information about follow-up after a behavioral health discharge.
- Substance use disorders (SUDs) are prevalent and far reaching. Early detection in the primary care setting and a comprehensive treatment plan including behavioral health specialty services can set patients on the path to wellness. View the Substance Use Disorders in the Primary Care Setting article in the March 2022 issue of Provider Update for more information about how primary care providers (PCPs) are being encouraged to assess patients enrolled in all products and appropriately refer them for assistance. It is encouraged for providers to share the alcohol and substance abuse brochure as a resource for your patients who may benefit from the information.
- Information regarding Consolidated Appropriations Act: No Surprises Act can be found under Provider News on the Tufts Health Plan public website.
- On a quarterly basis, providers should review and verify the accuracy of their demographic data displayed in the Provider Directory. Any changes to data should be reported in the CAQH ProView® tool.
- Office Manager Meetings information can be found at https://tuftshealthplan.com/provider/training/office-managers-meetings.
- Webinar information can be found at: tuftshealthplan.com/provider/training/webinars
- See Provider Contact Information page attached.

United Healthcare – Mary Butler

- United Healthcare is transitioning most communications to contracted health care professionals (primary and ancillary) and facilities from paper to digital. This will include:
    - ❖ Appeal Decision Letters
    - ❖ Pre-service/prior authorization decision letters
    - ❖ Inpatient review letters, including concurrent, retrospective, length of stay and level of care
    - ❖ Extension for lack of clinical information letters
    - ❖ Complex care management and OrthoNet letters available in Document Library
- Digital communication can be found within the UnitedHealthcare Provider Portal. This will allow you to immediately view letters in this secure repository of claim-related information. It is encouraged to check this area daily.
- Effective June 1, 2022, United Healthcare will no longer send paper checks for claim payment. This change supports the efforts to accelerate payments to the practice by moving to digital transactions. If you are not currently enrolled in ACH with Optum Pay, you are encouraged to enroll by May 18, 2022. This will allow sufficient time for registration to be complete before United Healthcare stops mailing paper checks. All health care professionals not enrolled in ACH as of June 1, 2022, will begin receiving claim payments in the form of virtual card payments. Virtual card payments are credit card payments.
- As of June 1, 2022, United Healthcare will require prior authorization for all Upper GI Endoscopy and capsule endoscopy services. These prior authorization requirements may already be applicable for certain United Healthcare members if the planned site of service is an outpatient hospital. However, prior authorization will now be required regardless of the location where the procedure is planned to be performed. This change applied to UnitedHealthcare Commercial plan members.
- Providers will request authorization by using the Prior Authorization and Notification tool to submit clinical information and request authorization for your planned endoscopy services including, when applicable, the site of service.
- Radiology and cardiology CPT codes have been added to the prior authorization and notification list for UHC Community Plan, Commercial and Exchange plans.
- This prior authorization requirement does not apply to advanced imaging services provided in the follow place of service:
    - ❖ Emergency Room
    - ❖ Urgent Care Center
    - ❖ Observation Unit
    - ❖ Inpatient Stay

  Codes: 0697T, 0698T, 0710T, 0711T, 0712T, 0713T, 93319
- If you are unsure if prior authorization is required for your patient, use the Prior Authorization and Notification Tool.
- New radiation therapy prior authorization requirements are effective as of June 7, 2022.
- Prior authorization will be required and managed by Optum for the following outpatient radiation therapies for impacted health plans of UnitedHealthcare Medicare Advantage, UnitedHealthcare West Medicare Advantage & UnitedHealthcare Community Plan (Dual Special Needs Plan)
    - ❖ Proton beam therapy (PBT)

- ❖ Fractionation for intensity-modulated radiation therapy (IMRT, PBT and standard 2D/3D radiation therapy for prostate, breast, lung and bone metastasis cancers
- ❖ Image-guided radiation therapy (IGRT)
- ❖ Special and associated radiation therapy services
- ❖ Selective internal radiation therapy (SIRT), Yttrium 90 (Y90) and implantable beta-emitting microspheres for treatment of malignant tumors

- Coverage changes for prenatal ultrasounds start on 6/1/2022. UnitedHealthcare will cover up to 3 prenatal ultrasounds that aren't associated with a high-risk diagnosis for CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816 and 76817 for UnitedHealthcare commercial members. This coverage is for professional claims only in a non-ER or inpatient setting. You may not balance bill unless you receive a written approval from the member prior to the service. UHC will make a coverage determination post-service pre-pay.
- Two new enhancements within the Prior Authorization and Notification tool in the UnitedHealthcare Provider Portal.
  - ❖ Cancel Case – You can submit a request to cancel most prior authorization request from within the Prior Authorization and Notification Tool. This does not apply to the following specialties including Radiology, cardiology, oncology, outpatient therapy, behavioral, specialty pharmacy and genetic/molecular testing
  - ❖ Save as Draft – Your prior authorization requests are now automatically saved and drafts are easily accessible from within the Prior Authorization and Notification tool.
- UnitedHealthcare has compiled various resources which can help make you and your practice more successful with patient experience. Visit UHCProvider.com and review available resources for CAHPS and HOS in the Reports and Quality Programs section. CAHPS survey administered February-June. HOS survey administered August-November. Federally mandated surveys used to gather patient feedback annually to better understand consumer health care experiences and outcomes. Paper surveys issued out by CMS/NCQA. Random sample of consumers and health plan members selected to participate. Consumer participation is voluntary.
- In accordance with 21st Century Cures Act regulations, all providers rendering services to Medicaid or Medicare members must be enrolled with the State in which those members are covered.
- UnitedHealthcare Community Plan is complying with those regulations and the guidance outlined by MassHealth for providers rendering services to Senior Care Options and One Care members.
- Changes in federal law require all MCE network providers to enroll with MassHealth. This means all MCE network providers must have two provider contracts in place:
  - ❖ A network provider contract with UnitedHealthcare Community Plan of Massachusetts
  - ❖ A provider contract with MassHealth. (MassHealth has developed a specific provider contract for this purpose, called the MassHealth Nonbilling Managed Care Entity (MCE) Network-only Provider Contract. This specific provider contract does not require a UnitedHealthcare Community Plan

network provider to render services to MassHealth fee-for-service members. Please note: A mailing will be going out shortly to those providers needing to enroll with Mass Health. Please complete the process within 30 days of receiving the letter. https://www.mass.gov/forms/mce-nonbilling-network-only-contract • Visit https://www.medicaid.gov for more information.

- United HealthCare does not allow back dating of authorizations.

UniCare – Terry Haneffant

- UniCare has 4 plan options that require no referrals to specialist, PCP selection encouraged, not required and Coverage for emergency & urgent care services at 100%:
  - ❖ Basic
  - ❖ PLUS
  - ❖ Community Choice
  - ❖ Medicare Extension
- Plan highlights:
  - ❖ Basic - Members can live anywhere in the world, provides worldwide coverage for any licensed doctor or hospital, members have the same copayments for all hospitals
  - ❖ PLUS - Members must live in MA, CT, ME, NH or RI, all Massachusetts hospitals are considered PLUS, Massachusetts hospitals are tiered, Out-of-State hospitals are all Tier 2
  - ❖ Community Choice - Members must live in Massachusetts , access to 58 Community Choice hospitals throughout MA and 80% coverage at non-Community Choice hospitals (100% coverage for emergencies)
- UniCare requires notification for certain procedures and services, to determine eligibility for benefits.
- Contact AIM Specialty Health directly for services they will be reviewing (such as echocardiography and high-tech imaging) by phone at 866-766-0247 or by the Provider portal: aimspecialtyhealth.com/goweb.
- Services remaining under UniCare review can call 800-442-9300 or fax information to 877-745-8636.
- New Interactive Care Reviewer (ICR) Portal through Availity. To register for training session, go to link at https://anthemub.webex.com/anthemub/onstage/g.php?PRID=47f0047a2af9d72e9f72f7e4b1a6e71e.
- Contact Express Scripts for most specialty drug questions or patient-related pharmacy questions: 1-855-283-7679.
- Behavioral Health Authorizations and Substance Abuse service authorizations will continue to be provided by Beacon. Beacon has a new ProviderConnect system at https://www.valueoptions.com/pc/eProvider/providerLogin.do.
- Beacon has a dedicated EDI Helpdesk for direct support with ProviderConnect at 888-247-9311 or E-mail at e-supportservices@beaconhealthoptions.com.
- Appeals for reconsideration of a denial by Managed Care department must be filed in writing. All supporting documentation must be received within 3 business days of when the denial was received.

- Appeals for claims reconsideration must be received by UniCare within 180 days of when the determination was made. Send appeal requests and supporting documentation to:
    - UniCare State Indemnity Plan
      PO Box 2011
      Andover, MA 01810
      Fax# 978-474-5179 (Managed Care)
- GIC health plans tier Massachusetts specialty care physicians at the group level based on affiliation with Hospital under the CHIA hospital category.
- A patient's office visit copay is determined by the tier for each specialist providing treatment.
- Tier of Specialist applies to all UniCare Plan with the exception of Medicare Extension:
    - Tier 1 - $30 copay
    - Tier 2 - $60 copay
    - Tier 3 - $60 copay- Basic Tier 3 - $75 copay – PLUS & CC
    - See our website for more details on tiering
- Hospital Tiering - applies to the PLUS Plan –Beth Israel and BI Affiliates are Tier 2. Hospital Tier determines the copay for services. Inpatient Services copayments:
    - Tier 1 - $275 copay
    - Tier 2 - $500 copay
    - Tier 3 - $1500 copay
- Plan updates as of 7/1/2022 all are Behavioral Health related:
    - In home behavioral services - In home behavioral services (IHBS) have similar levels of care to ABA but there is a subset of the population that would benefit from IHBS.
    - Family Support and training - This service provides peer to peer support for a caregiver of a child with serious emotional disturbance (SED) to help them navigate the system and access services for their child. There is no substantially similar service being covered today.
    - Therapeutic mentoring services - This services provides 1:1 support and skill building for youth. There is no substantially similar service being covered today.
    - Mobile Crisis Intervention - The emergency service program includes children but this service expands on that coverage by allowing services in additional settings.
    - Intensive Care Coordination - This service provides coordination for members who have multiple services and systems involved. This would support our whole health whole you program as providers live in the same area as the member.
- Our website unicaremass.com has up to date information on COVID-19 treatment and coverage.
- Telehealth services will continue to be covered, but beginning July 1, 2021, standard office visit copays will apply for non-COVID related services. Services for the diagnosis and treatment of COVID-19, including lab testing, provider visits, and inpatient services are covered with no member cost share. COVID vaccines are covered by UniCare with no member cost share. Including newly added boosters.

- To submit requests & Information to UniCare use the shared mailbox at unicareproviderrelations@anthem.com.
- This mailbox is checked daily to ensure a timely response to your request. Use this mailbox to submit changes on the below:
  - ❖ Roster Updates
  - ❖ Enrollment forms
  - ❖ Demographic updates
  - ❖ Terminations
- Physicians that are delegated are credentialed by the contract Entity.
- Physician's that are not under a delegated agreement. Will be credentialed by UniCare's Credentialing staff.
- UniCare requires CAQH for providers who participate in the UniCare network Unicare follows the National Committee of Quality Assurance (NCQA) standards for more information contact us at: Phone: (800) 480-7587 Fax: (978) 474-6188 or email to unicareproviderrelations@anthem.com.
- Accurate provider data is key to effective provider transactions and communication. Roster updates are completed to note provider changes in your group and reflect the updates in the UniCare system. Practices must notify UniCare when a provider leaves or joins their group. Requests to change financial addresses must be submitted in writing with a W-9 form.
- See Provider Tools & Resources attached.

US Family Health Plan – Thomas Leonard

- TRICARE health plan option. Separate Contract from TRICARE.
- Six separate service areas across the U.S.
- TRICARE Prime equivalent with added value-based programs. Same open enrollment season as other TRICARE Plans.
- Tufts Health Plan Relationship – Third Party Administrator – Same Payer ID – 04298.
- Submit USFHP referrals through Tuft's portal or via paper (USFHP referral forms)
- Specific member information and/or questions if a Prior Authorization is required call (800) 818-8589.
- Providers must be credentialed with Tufts Health Plan – commercial product before they can become a provider with USFHP.
- Providers must be affiliated with an in network USFHP hospital.
- PCPs have a unique USFHP ID.
- USFHP must be notified separately from THP.
- ALL PCP Adds and Terms must be communicated directly to USFHP.
- ALL practice location, phone number and panel status changes must be updated through Direct Assure.
- Log onto www.usfamilyhealth.org to check if provider information is correct.
- US Family Health Plan / TRICARE is not subject to state mandates. Effective as of May 12, 2020 through the expiration of the President's national emergency for the COVID-19 outbreak:
  - ❖ Administrative services are not separately reimbursed services
  - ❖ USFHP is accepting GQ, GT, and 95 Modifiers

    - ❖ Audio-only telephonic office visits will be covered represented by – CPT 99441-99443; 98966-98968; HCPCS G2012.
    - ❖ Routine physicals are not covered for telehealth.
    - ❖ Temporarily waiving any cost sharing and copayments for all covered in-network telehealth services.
- Coronavirus Vaccination will be reimbursed at the local Medicare Rates for the administrative costs.
- Active-duty families and Retirees can enroll during our open season. This is the only time of year TRICARE Select members can enroll with USFHP.
- TRICARE Prime members can switch to USFHP any time throughout the year.
- Qualifying Life Event is needed in order to change outside of Open Enrollment Season (up to 90 days after a QLE).
- US Family Health Plan updates are located on our website's home page along with our provider manual.
- Heart to Heart e-news letter provides important USFHP provider updates.
- Register for the newsletter by USFHP website or emailing USFHP at Thomas.Leonard@usfamilyhealth.org.

Easy Reference grid

Prior authorization reference guide for limited network products

Our prior authorization processes are slightly different for providers who are contracted with AllWays Health Partners but not participating in one or more of our limited network products.

The below grid will help direct you to submit requests to the appropriate location.

Authorization requests	**Participating** Contracted for all lines of business	**Non-participating** Contracted but not participating in the limited network product	**Not contracted** Not contracted with AllWays
Medical	AllWays portal	AllWays portal	Non-contracted form
Behavioral health	Optum portal	Optum portal	Optum portal
Med specialty (AllWays Health Partners)	AllWays portal	AllWays portal	Non-contracted form
Med specialty (Novologix)	Novologix tool in the AllWays portal	AllWays PA tool in the AllWays portal	Non-contracted form
Pharmacy through CVS Caremark (carved in)	CVS Caremark – check here for correct phone number	CVS Caremark – check here for correct phone number	Non-contracted form
High-tech radiology, cardiac imaging, genetic testing	EviCore portal	AllWays portal	Non-contracted form
Sleep studies	CareCentrix portal	AllWays portal	Non-contracted form

How do I know if I am participating in a limited network product?
You will receive an alert regarding your participation in the network when you check a member's eligibility in the AllWays Health Partners provider portal.

You can also confirm your participation in the limited networks by checking our online Provider Directory

What is the difference between Non-participating and Not contracted?
Non-participating means you are a contracted provider with AllWays Health Partners however you are not part of that particular limited network. Non contracted refers to a provider or group who is not contracted with AllWays Health Partners for any lines of business.

Who are the Plan's Clinical Vendors?

Beacon Health Strategies

Behavioral Health

- Available 24/7 for members and providers.
- Manages inpatient and outpatient behavioral health and substance use services, and will be contracting on behalf of the ACO for BH Community Partner services.
- Prior authorization may be required for certain services.

Visit: Beacon's website for more resources or to find a provider
Call Beacon Health Strategies at:

For QHP Members: 1-888-217-3501
For ACO and MCO Members: 1-877-957-5600
For SCO Members: 1-855-833-8125

Northwood

Durable Medical Equipment, Prosthetics, and Orthotics

- Manages durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) network.
- Prior authorization is required for all DMEPOS dispensed and billed by a DMEPOS supplier.

Visit: Northwood, Inc.
Call: 866-802-6471

Who are the Plan's Clinical Vendors?

Express Scripts **Pharmacy Benefits**	▪ Submit a coverage review request online through one of these ePA portals: Surescripts, CoverMyMeds, or ExpressPAth. ▪ If you do not have access to an ePA system, you may contact Express Scripts to submit your request at 877-417-1822 (for MassHealth members) or 877-417-0528 (for Qualified Health Plan members), or you can submit the General Medication Request Form
eviCore **High End Radiology**	▪ Manages outpatient non-emergency high end radiology (MRI, CT, PET, Nuclear Cardiology) ▪ Prior authorization may be required for certain services. ▪ Visit: eviCore (formerly MedSolutions) Call: 866-802-6471
AxisPoint Health **Nurse Advice Line**	▪ Available 24/7 for members ▪ An audio health library of recorded information, by topic, can be accessed through the advice line ▪ Call: 866-763-4695 (ConnectorCare/QHP) ▪ Call: 800-973-6273 (MH)

Key Contacts

General Contact Information
(413) 787-4000 | (800) 842-4464
healthnewengland.org
Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500

Health Services (Behavioral Health)
(413) 787-4000 | (800) 842-4464 Ext. 5028
For questions regarding:
- Prior approval
- Out-of-plan requests
- Case management

Health Services (Medical)
(413) 787-4000 | (800) 842-4464 Ext. 5027
For questions regarding:
- Prior approval
- Out-of-plan requests
- Case management

HNEDirect Provider Portal
(413) 787-4000 | (800) 842-4464 Ext. 3311
Email questions to: HNEDirect@hne.com
For questions regarding:
- Login or password assistance
- Portal functionality

Member Services/Enrollment
(413) 787-4000 | (800) 842-4464 Ext. 5025
For questions regarding:
- Benefits
- Eligibility
- Copayment

Provider Claims Servicing Unit
(413) 787-4000 | (800) 842-4464 Ext. 5026
For questions regarding:
- General claim inquiries

Provider Contracting
Fax/Phone: (413) 233-3175
Email questions to: PContracting@hne.com
For questions regarding:
- Contracting status

Provider Credentialing
(413) 787-4000 | (800) 842-4464 Ext. 3980
Email questions to: ProvCred@hne.com
For questions regarding:
- Credentialing status

Provider Enrollment
(413) 787-4000 | (800) 842-4464 Ext. 5038
Email questions to: PEnrollment@hne.com
For questions regarding:
- Provider demographic information
- Tax ID/billing information/ERA enrollment/1099 information

Provider Relations
(413) 787-4000 | (800) 842-4464 Ext. 5000
healthnewengland.org/provider-contact
Email questions to: ProviderRelations@hne.com
For questions regarding:
- Reimbursement issues
- Complex claims issues
- Educational visit requests

JK Contact Information

- **IVR:** 877-869-6504
- **Provider Contact Center:** 866-837-0241
- **Fax on Demand:** 866-709-1905
- **EDI Helpdesk:** 888-379-9132
- **Correspondence**
  - National Government Services
    Part B Provider General Written Inquiries
    P.O. Box 6189
    Indianapolis, IN 46207-6189
- **Direct telephone number for Provider Enrollment (JK):** 888-379-3807

National Government Services

NGS MU

Appendix

Table 1A. Full List of all Z Codes and Sub-codes Included in Analysis.

Z code	Description	Number of Sub-codes
Z55	Problems related to education and literacy	7
Z55.0	Illiteracy and low-level literacy	-
Z55.1	Schooling unavailable and unattainable	-
Z55.2	Failed school examinations	-
Z55.3	Underachievement in school	-
Z55.4	Educational maladjustment and discord with teachers and classmates	-
Z55.8	Other problems related to education and literacy	-
Z55.9	Problem related to education and literacy, unspecified	-
Z56	Problems related to employment and unemployment	9
Z56.0	Unemployment, unspecified	-
Z56.1	Change of job	-
Z56.2	Threat of job loss	-
Z56.3	Stressful work schedule	
Z56.4	Discord with boss and workmates	-
Z56.5	Uncongenial work environment	-
Z56.6	Other physical and mental strain related to work	-
Z56.8	Other problems related to employment	
Z56.9	Problem related to employment, unspecified	-
Z57	Occupational exposure to risk factor	10
Z57.0	Occupational exposure to noise	-
Z57.1	Occupational exposure to radiation	
Z57.2	Occupational exposure to dust	-
Z57.31	Occupational exposure to environmental tobacco smoke	-
Z57.39	Occupational exposure to other air contaminants	
Z57.4	Occupational exposure to toxic agents in agriculture	-
Z57.5	Occupational exposure to toxic agents in other industries	-
Z57.6	Occupational exposure to extreme temperature	
Z57.8	Occupational exposure to other risk factors	-
Z57.9	Occupational exposure to unspecified risk factor	-
Z59	Problems related to housing and economic circumstances	10
Z59.0	Homelessness	-
Z59.1	Inadequate housing	-
Z59.2	Discord with neighbors, lodgers, and/or landlord	-
Z59.3	Problems related to living in a residential institution	-
Z59.4	Lack of adequate food and/or safe drinking water	-
Z59.5	Extreme poverty	-
Z59.6	Low income	-
Z59.7	Insufficient social insurance and welfare support	-

Z59.8	Other problems related to housing and economic circumstances	-
Z59.9	Problem related to housing and economic circumstances, unspecified	-
Z60	Problems related to social environment	7
Z60.0	Problems of adjustment to life-cycle transitions	-
Z60.2	Problems related to living alone	-
Z60.3	Acculturation difficulty	-
Z60.4	Social exclusion and rejection	-
Z60.5	Target of (perceived) adverse discrimination and persecution	-
Z60.8	Other problems related to social environment	-
Z60.9	Problem related to social environment, unspecified	-
Z62	Problems related to upbringing	7
Z62.0	Inadequate parental supervision and control	-
Z62.1	Parental overprotection	-
Z62.2	Upbringing away from parents	-
Z62.3	Hostility towards and scapegoating of child	-
Z62.6	Inappropriate (excessive) parental pressure	-
Z62.8	Other problems related to upbringing	-
Z62.9	Problem related to upbringing, unspecified	-
Z63	Other problems related to primary support group, including family circumstances	9
Z63.0	Problems in relationship with spouse or partner	-
Z63.1	Problems in relationship with in-laws	-
Z63.3	Absence of family member	-
Z63.4	Disappearance and/or death of family member	-
Z63.5	Disruption of family by separation and/or divorce	-
Z63.6	Dependent relative needing care at home	-
Z63.7	Other stressful life events affecting family and household	-
Z63.8	Other problems related to primary support group	-
Z63.9	Problem related to primary support group, unspecified	-
Z64	Problems related to certain psychosocial circumstances	3
Z64.0	Problems related to unwanted pregnancy	-
Z64.1	Problems related to multiparity	-
Z64.4	Discord with counselors	-
Z65	Problems related to other psychosocial circumstances	8
Z65.0	Conviction in civil and/or criminal proceedings without imprisonment	-
Z65.1	Imprisonment and other incarceration	-
Z65.2	Problems related to release from prison	-
Z65.3	Problems related to other legal circumstances	-
Z65.4	Victim of crime and/or terrorism	-
Z65.5	Exposure to disaster, war, and other hostilities	-
Z65.8	Other problems related to psychosocial circumstances	-
Z65.9	Problem related to unspecified psychosocial circumstances	-

Provider Contact Information

Harvard Pilgrim Health Care Provider Website: harvardpilgrim.org/provider

Provider Service Center

- Phone: 800.708.4414
- Email: provider_callcenter@point32health.org*

Medicare Advantage Provider Service Center

- Phone: 888.609.0692

Behavioral Health Access Center

- Phone: 888.777.4742

E-Services/HPHConnect Service Center

- Phone: 800.708.4414 (Option 1; then 6)
- Email: Provider_eBusiness_Services@point32health.org*

E-Services/EDI-Direct

- Phone: 800.708.4414 (Option 1; then 3)
- Email: EDI_Team@point32health.org*

* New email addresses

Provider Contact Information

Tufts Health Plan Provider Website: tuftshealthplan.com/provider

Provider Services:

- Tufts Health Plan Commercial Provider Services: **888.884.2404**
- Tufts Health Public Plans Provider Services (MA): 888.257.1985
- Tufts Health Public Plans Provider Services (RI): 844.301.4093
- Tufts Health Plan Medicare Preferred HMO and Tufts Health Plan Senior Care Options Provider Relations: 800.279.9022

Commercial and Senior Products Behavioral Health Department: 800.208.9565

Technical Inquiries: Tufts_Health_Plan_Provider_Technical_Support@point32health.org*

Provider Education: Provider_Education@point32health.org*

* New email addresses

UniCare

Provider Tools & Resources

Visit **unicaremass.com** > Provider Tab

- Plan resources include:
  - Medical and reimbursement policies
  - Provider News Letters
  - Member handbooks
  - Notification requirements
  - Physician Listing with tier levels for specialists
  - Electronic claims filing and registering for EFT and ERA (EnrollHub)

- Availity:
  - Web portal: Verify eligibility, check and submit claims
    Availity Client Services 1-800-282-4548 M-F 8:00 to 7:30 EST.

- Contact Information:
  Terry Haneffant – 978-474-5139, email Theresa.Haneffant@anthem.com
  Provider Relations – 800-480-7587, email unicareproviderreleations@anthem.com