GREY LEDGE
MEDICAL MANAGEMENT
Formerly Comprehensive Practice Management Services

MEMORANDUM

To:	***GLMM Clients & GLMM Staff***
From:	***Karen Marcoux, CPC, Sue Kandzerski, CPC, JoAnn Beahm, CPC & Michelle King Green***
Date:	***December 30, 2022***
Subject:	***Highlights from Rhode Island MGMA Virtual Payer Day***

The following information was shared by the Rhode Island insurance companies at the recent Annual Rhode Island MGMA Virtual Payer Day meeting.

Point32 Health – Kelly Farewell

- Harvard Pilgrim Health Care and Tufts Health Plan Have combined
- The name of the parent organization is Point32Health.
- 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.
- Continue to follow the existing processes for each insurance.
- Point32 offers commercial, senior and public plans that deliver accessible and affordable quality care to everyone —no matter their age, health or income.
- To keep the network providers aware of the work Point32 has done in transitioning their technologies, processes, and products and share the plans for what's ahead, the respective public websites for Harvard Pilgrim Health Care and Tufts Health Plan include integration updates with information about:
    - Products
    - Billing and Reimbursement
    - Pharmacy
    - Medical Management and Continuity of Care
    - Behavioral Health
    - Electronic Tools
    - Contracting
    - Provider training events will be posted on heritage brand websites
- Point32Health has been evaluating products offered by Harvard Pilgrim Health Care and Tufts Health Plan.
- The Commercial business is moving to a more unified product portfolio and certain products are being integrated.

- Members of Commercial Tufts Health Plan products will begin migrating to Harvard Pilgrim Health Care products beginning January 1, 2023.
- Beginning January 1, 2023, Tufts Health Plan **Massachusetts** employer group clients and members of individual and small group products will begin transitioning to the Harvard Pilgrim Health Care product portfolio.
- Transitions will occur on each employer group's renewal date and will continue throughout 2023 and 2024.
- Additional segments of the Tufts Health Plan employer group clients and members will migrate to Harvard Pilgrim Health Care products in 2024.
- All members who are changing plans will receive a new member ID card prior to their effective date.
- Point32 encourages providers to check eligibility and benefits using the online provider tools.
- You can check member eligibility and benefits for Harvard Pilgrim Health Care members using our HPHConnectportal.
- To check member eligibility and benefits for Tufts Health Plan members, visit the Tufts Health Plan secure provider portal.
- Continue to call the member's appropriate heritage organization with questions by referring to the member ID card for contact information.
- Point32Health has selected OptumRx as the pharmacy benefit manager for all products, effective January 1, 2023.
- OptumRx will offer convenient and affordable access to prescription medications to members through a comprehensive retail, specialty and home delivery pharmacy network.
- Point32Health will continue to manage its own pharmacy programs, including drug formularies and the development of utilization management criteria.
- Point32Health is unifying our medical necessity guidelines within product lines, but guidelines may vary across product lines such as Commercial and Public Plans.
- The 2023 prescription drug formularies will take effect on January 1, 2023 and will be posted to their legacy organizations' respective provider websites in November.
- Look for updated information in *Network Matters* and *Provider Update*.
- Both heritage organizations offer behavioral health programs by operating different models to meet the members' needs. Currently, Tufts Health Plan operates its own network of behavioral health providers, while Harvard Pilgrim Health Care offers behavioral health services through a contract with Optum/United Behavioral Health.
- Point32Health will offer an insourced behavioral health program.
- With an effective date of July 1, 2023, behavioral health coverage and programs, including utilization and care management, will be delivered through Point32Health's own internal functions and behavioral health team.
- The insourced behavioral health program will utilize a whole-health network of both medical and behavioral providers, emphasizing highly coordinated care management and outreach that connects behavioral health and physical health.
- There are no immediate policy or procedural changes for behavioral health providers, but additional information will be forthcoming prior to insourcing.

- The corporate address of Point32Health, the parent organization of Harvard Pilgrim Health Care and Tufts Health Plan is 1 Wellness Way, Canton, MA 02021-1166
- 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.
- Mail forwarding will be available until **December 1, 2022** to give providers time to make updates to their systems.
- Harvard Pilgrim Health Care's paper claims submission addresses remain unchanged. View the Claim Submission Guidelines to obtain the mailing address for each type of claim.
- View Tufts Health Plan's updated paper claims submission mailing addresses in the Claims Requirements, Coordination of Benefits and Payment Disputes chapter of the Commercial, Senior Plans and Tufts Health Public Plans Provider Manuals.
- Throughout 2022, Point32 has been reviewing and assessing the medical necessity guidelines, prior authorization requirements including InterQual SmartSheets and payment policies to align them for greater ease and efficiency.
- The majority of guidelines have already been reviewed, and they expect the rest to be reviewed by January 2023.
- Point32 will announce any significant changes and new policies through our monthly provider newsletters.
- Refer to *Network Matter s*and *Provider Update* for updates.
- In the early days of the COVID-19 pandemic, Harvard Pilgrim Health Care and Tufts Health Plan developed temporary Telehealth/Telemedicine Payment Policies to expand the scope of coverage during the pandemic, and offer guidance on coverage and billing to address the unique needs of providers and members during the unprecedented public health crisis.
- For dates of service beginning September 1, 2022, the interim policies have been retired, and new Payment Policies are in effect.
- All telehealth services will continue for the time being to be reimbursed at parity to in office services.
- Refer to the new Harvard Pilgrim Health Care Telehealth/Telemedicine Payment Policy and the Tufts Health Plan Telehealth/Telemedicine Payment Policy effective for dates of service on or after September 1, 2022, for complete information.
- Visit the COVID-19 Information and Resources page to access valuable information on Harvard Pilgrim Health Care's adapted policies and business operations, aimed at supporting providers through the COVID-19 public health emergency.
- Visit the COVID-19 Updates for Providers page for the most up-to-date information about Tufts Health Plan's policies and coverage relating to COVID-19.
- Point32Health is now collaborating with Monogram Health for in-home chronic kidney disease (CKD stages 3b-5) and end-stage renal disease (ESRD) care management services for Harvard Pilgrim Health Care and Tufts Health Plan Commercial fully insured members, effective September 1, 2022.
- Monogram Health is a leading value-based provider of in-home nephrology, primary care, and benefit management services for individuals with CKD and ESRD.

- To supplement the care provided by the member's nephrologist, Monogram provides high-touch, in-person care through an interdisciplinary care team.
- For more information about Monogram Health, visit monogramhealth.com.
- If you have questions, contact Monogram Health's Provider Services at 855-529-2778 or PCPservices@monogramhealth.com.
- Information on the No Surprises Act can be found on the Harvard Pilgrim Health Care website and the Tufts Health Plan website.
- **Subscribe to Network Matters at harvardpilgrim.org/provider/news-center/network-matters**
- **Subscribe to Provider Update at tuftshealthplan.com/provider/provider-news/news-center**
- Harvard Pilgrim Health Care knows how important it is for providers to meet the needs of patients and provide the most culturally appropriate care possible. To that end, Harvard Pilgrim would like to remind providers that they have language interpretation services available to aid in the care of patients.
- Providers can access the free languages interpretation services in more than 160 languages whenever you need them to support your patients by calling 800-264-1548.
- Teletypewriter (TTY) telephone technology is also available for communicating with deaf and hearing-impaired patients. Harvard Pilgrim Health care uses Telecommunications Relay Service (TRS), a public service, for TTY communications. To access TRS, call 711.
- **Credentialing & Contracting Overview - harvardpilgrim.org/provider/resource-center/join-our-network/, select Join the Network**
- **Provider Website - harvardpilgrim.org/provider**
- The public Provider website features:
    - Easy-to-navigate design
    - Filtering and search functionality
    - Centralized information:
    - Payment Policies
    - Medical Policies
    - Provider Manual
    - Network Matters
- HPHConnect – the secure provider portal is your primary tool to manage your Harvard Pilgrim Health Care patients.
- Enhanced Features:
    - Centralized resources
    - Smooth search capabilities and time saving templates
    - 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.

- Provider Training and Events - 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.
- 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*

Tufts Health Public Plans – Kelly Farewell

- On October 1, 2022, Tufts Health Plan implemented a genetic testing prior authorization program for Tufts Health Public Plans members, which will be managed by AIM Specialty Health (AIM).
- The program requires ordering providers to obtain prior authorization through AIM for the following genetic/genomic or molecular diagnostic testing services:
    - Reproductive Carrier Screening
    - Prenatal Testing
    - Preimplantation Genetic Testing (PGT)
    - Rare Disease Testing
    - Whole Exome/Genome Sequencing
    - Hereditary Cancer Testing
    - Tumor Markers
    - Hereditary Cardiac Testing
    - Neurogenetic and Neuromuscular Testing
    - Pharmacogenomics and Thrombophilia Testing
    - Susceptibility Testing for Common Diseases
- The ordering clinician is responsible for obtaining prior authorization through AIM.
- Any genetic/genomic and molecular tests performed on or after October 1, 2022 will not be reimbursed if a prior authorization was not obtained. Providers

rendering the services should verify that the necessary prior authorization has been obtained prior to performing the test.

- Submitting Authorization Requests Ordering providers can request prior authorization from AIM online (the preferred method for quick, convenient service) via the *AIM ProviderPortal*, which is available 24 hours a day, 7 days a week. Alternatively, requests may be submitted by phone by calling AIM toll-free at 833-342-1255, Monday through Friday from 8 a.m. to 5 p.m. ET.
- For more information, including the list of CPT codes applicable to the program, refer to the Prior Authorization Program for Genetic Testing section of the Tufts Health Plan Vendor Information page on the Provider website, as well as this provider FAQ document about the program. Additional prior authorization information, including AIM's genetic testing clinical guidelines and other resources are available on the microsite AIM has developed specifically for Point32Health, which includes Tufts Health Plan and Harvard Pilgrim Health Care.
- Effective for dates of service beginning November 1, 2022, Tufts Health Plan will require prior authorization for coverage of prenatal genetic testing for Commercial members managed by AIM Specialty Health.
- For complete information, including clinical coverage criteria, applicable coding, and coverage limitations, refer to: Tufts Health Plan's updated Medical Necessity Guidelines for Genetic Testing: Prenatal Diagnosis, Carrier Screening(formerly titled Medical Necessity Guidelines: Genetic Testing: Prenatal, Preconception)
- Tufts Health Plan knows how important it is for providers to meet the needs of patients and provide the most culturally appropriate care possible. To that end, we would like to remind you that we have language services available to aid in the care of your patients.
- **Providers can access our language services by calling the following phone number:**
  Tufts Health RITogether: 844-301-4093
- For more information, refer to the Providers chapter of the Tufts Health Public Plans Provider Manual, which is available in the Resource Center of the public Provider website.
- Paper claims for to Massachusetts and Rhode Island Public Plans should be sent to the following respective addresses:

  Massachusetts Paper Claim Submissions:
  Tufts Health Public Plans – Paper Claims Submissions
  Manhattan Data LLC
  26741 Portola Pkwy, Ste 1E # 926
  Foothill Ranch, CA 92610-1763

  Rhode Island Paper Claim Submissions:
  Tufts Health Public Plans – Paper Claims Submissions
  Manhattan Data LLC
  26741 Portola Pkwy, Ste 1E # 925
  Foothill Ranch, CA 92610-1763

- Tufts Health Plan has partnered with Cortica, Inc. to offer convenient access to services for pediatric members with autism spectrum disorder (ASD) and other neurodevelopmental conditions.
- Cortica offers a unique approach to care that integrates behavioral health care, medical care, and therapies through an interdisciplinary team of employed pediatric neurologists, developmental pediatricians, nurse practitioners, therapists, and counselors who specialize in neurodevelopment.
- PCPs and other providers can refer members to Cortica by visiting their website and clicking the "Make a Referral" button in the top right corner to access an online referral form.
- Alternatively, you can make a referral by calling Cortica at 858-251-7901or by emailing enroll@corticacare.com. If you choose to submit a referral by email, include your name/the provider's name, the patient's name and contact information, and the reason for the referral.
- The Rhode Island Executive Office of Health and Human Services announced that doula services will be added to the Medicaid benefit package retroactively for dates of service on or after July 1, 2021.
- Coverage for doula services for Tufts Health RITogether members includes:
    - Three prenatal visits
    - One labor and delivery visit
    - Three postpartum visits
- As a preventive health service, doula services must be recommended for a patient. It is not a formal referral, and does not require a referral form. The provider recommends a doula (certified by the state of Rhode Island) to the member.
- Recommendation must be documented in a recommending practitioner's electronic health record.
- Patients may request a written recommendation to provide to the doula.
- For more information, refer to the Obstetrics/Gynecology Professional Payment Policy.
- To check the status of a doula's certification, visit the Rhode Island Certification Board website.
- Effective for members of Rhode Island, fully-insured Commercial plans that are issued or renewed on or after July 1, 2022, Tufts Health Plan will provide coverage of doula services including:
    - Up to two antepartum visits
    - In-person labor and delivery support
    - Up to two postpartum visits
- Perinatal doula services do not require a PCP referral or prior authorization.
- Tufts Health Plan has updated the Obstetrics/Gynecology Professional Payment Policy to reflect this coverage.
- As part of Tufts Health Plan ongoing efforts to improve efficiency and enhance provider experience, an email box has been established specifically for Commercial Rhode Island Providers.
- The new email box is RIProviderEnrollment@point32health.org.
- Commercial Rhode Island Providers may submit the following through the new email box:
    - Credentialing and provider enrollment information
    - Affiliation additions or terminations

    - Panel status changes
    - Billing information updates
    - Contract changes
- Credentialing and Contracting at Tuftshealthplan.com/provider/credentialing-and-contracting/overview
- For additional information, view the:
    - Summary of the Credentialing Process chapter of the Commercial Provider Manual
    - Summary of the Credentialing Process chapter of the Tufts Health Public Plans Provider Manual
- Tufts Health Plan's Provider Education Team offers a variety of training opportunities for providers and office staff at: tuftshealthplan.com/provider/training/overview
- Office Managers Meetings at: tuftshealthplan.com/provider/training/office-managers-meetings
- 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

  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

Neighborhood Health Plan of Rhode Island – Monica Osorio & Marcos Sprovieri, Sr.

Medicaid

- New Plans for those eligible for Medicaid through the State of Rhode Island.
    - All children covered regardless of immigration status
    - Post-partum women now covered for 12 months, regardless of status

Medicare-Medicaid Plan (MMP) INTEGRITY

- A quality health and drug plan for individuals eligible for both Medicare and Medicaid.
    - *For calendar year 2023*-Apersonal emergency response system (PERS) will no longer require an LTSS application
    - *For calendar year 2023*-Authorization requirements will be removed for up to 24 visits for outpatient occupational, physical, and speech therapy

Commercial Plans: For individuals, families, & small businesses

- *New for 2023!* PEAK small group HMO plan and PEAK Elite POS plan
- Value Added Services at No Cost to all Commercial Members
    - $0 co-pay for hypertension medications in tiers 1-4
    - No-cost in-office interpreter services
    - Pyx Health mental wellbeing app
    - LunaYou personalized pregnancy program

- For more information on individual and family plans, visit: https://www.nhpri.org/members/commercial-members-individual-family-plans/
- Neighborhood offers a variety of plans for small businesses (2-50 employees). For more information on plans for small businesses, visit: https://www.nhpri.org/members/commercial-members-small-business-plans/
- Neighborhood is contracted with NaviNet to provide online eligibility and claims status lookup 24/7. For Neighborhood's Commercial lines of business, NaviNet displays cost-sharing information, such as co-pay, deductible, out-of-pocket and pharmacy spend.
- All providers should verify a member's eligibility when providing services to a member(s) who present a Neighborhood ID card.
- ***New!*** The time span for claim history/single claim look-up has recently been increased to two years.
- When the Public Health Emergency (PHE) ends in Rhode Island, Medicaid members will need to renew their eligibility with the State to keep their health care. This process requires notifying the Medicaid beneficiary via mail (USPS). Having a current, accurate mailing address for all Medicaid beneficiaries is critical.
- The most important action you and your practice can take is to have beneficiaries update their individual and family account information, with NHP RI, so your patient's can receive the notices and information they need to maintain or transition coverage.
- Prior Authorization Reference Guides by Neighborhood Line of Business are searchable by procedure/service code or name to obtain authorization information; the particular code will display with any authorization requirements.
- Clinical Medical Policies are reviewed annually and updated accordingly based on a thorough review of current medical literature, standards of practice and criteria for prior authorization requirements
- Neighborhood's billing guidelines and payment policies are updated regularly and are subject to revisions per regulation and professional/industry standards.
- Prior authorization Reference Guides, Clinical Medical Policies & Payment Policies and Billing Guidelines can be accessed via the following webpage: https://www.nhpri.org/providers/policies-and-guidelines/
- Neighborhood continuously evaluates its covered versus non-covered services, for all lines of business.
- The Non--Covered Services Payment Policy is reviewed and revised quarterly to reflect the latest updates.
- Previous versions of all Neighborhood temporary and permanent payment policies and listed on Billing Guidelines and Payment Policies Archive webpage.
- As of July 1, 2022 the Telemedicine/Telephone Services policy has been updated
    - Place of service (POS) 10 language added.

    - All claims for telemedicine services must be billed on a CMS-1500 claim form.
- Telemedicine/Telephone Services policy includes two separate coding grids:
    - Listing of the permanent codes allowed for telemedicine
    - Listing of temporary codes allowed through December 2023
- Limiting telemedicine services at a CPT/HCPCS code level versus provider specialty (see policy for excluded provider specialty types).
- For complete information regarding the Telemedicine/Telephone Services Payment Policy, please view a copy of the formal provider notification from May 1, 2022 at this link: https://www.nhpri.org/wp-content/uploads/2022/05/News-and-Updates_New-Telemedicine_Telephone-Services-PCC-Final.pdf
- A credentialing application is considered complete when all of the required documents have been received by Neighborhood Credentialing. Application requirements are listed in Neighborhood's Provider Manual, beginning on page 78.
- Neighborhood renders a decision regarding the provider's application within **45** calendar days of receipt of a complete credentialing application.
- Providers are notified of the status of their credentialing application at least once every **15** calendar days, this notification will inform providers of any missing information.
- Providers are informed within **5** business days when the application is deemed complete.
- In order to be participate in Neighborhood's network, all practitioners and provider groups must be enrolled with Rhode Island Medicaid. If you are currently enrolled with RI Medicaid and require a new contract with Neighborhood, please visit: https://www.nhpri.org/providers/join-our-network/.
- The Update Your Information webpage on the Neighborhood provider website hosts many electronic forms (eForms) that you and your practice can use to notify Neighborhood of any important changes to your profile or practice.
    - Add a New Provider to a Currently Contracted Practice/Group
    - Billing Address Update
    - Practice Address Update
    - Change the Panel Status (Accepting New Patients) of a Current Provider
    - Change the Role (PCP or Specialist) of a Current Provider
    - Update Practice Location(s) for an Existing Provider
- Provider Services (Neighborhood's call center) is your first point of contact for any non-clinical inquiries, assistance with claims payment, and questions related to member benefits, eligibility, and prior authorization requirements. Provider Services at 1-800-963-1001, Monday – Friday from 8 a.m.to 6 p.m.
- Use Neighborhood's Quick Reference Guide for help with common questions and answers, as well as, frequently used telephone numbers.
- All provider forms, including forms and eForms for claims, interpreter services, and PCP changes are available on the www.nhpri.org website: https://www.nhpri.org/providers/provider-resources/forms/
- For more information on the No Surprise Act, please visit: https://www.cms.gov/nosurprises

UnitedHealthCare – Jacquelynn McDonald

- The credentialing process is the health care industry standard to collect and verify each health care professional's qualifications
- Credentialing assesses qualifications, relevant training, licensure, certification and/or registration to practice for each health care professional who participates in UnitedHealthcare networks. United Healthcare use this process to help make sure those in our network have the credentials required to care for our members.
- Credentialing standards are set by the National Committee on Quality Assurance (NCQA), as well as specific state and federal regulations for participation in the Medicaid and Medicare programs. UnitedHealthcare credentialing process complies with these standards. Some states may have additional requirements as part of the credentialing and recredentialing process. ** new providers for UHC must also participate in United Health RiteCare **
- Please ensure that all necessary parts of the credentialing application are completed and provide the following:
    - Training & Education
        - Practitioner degree (MD, DO or DPM), post-graduate education or training.
        - Details of medical or professional education and training
        - Completion of residency program in the designated specialty
    - Licensing & Certification
        - Current license or certification in the state(s) in which the care provider will be practicing.
        - National Provider Identification (NPI) number
        - Active Drug Enforcement Agency (DEA) number and/or Controlled Dangerous Substance (CDS) Certificate or acceptable substitute (if required)
        - Medicare/Medicaid participation eligibility or certification (if applicable)
    - Work History
        - Five-year work history
            - If any gaps longer than six months you will need an explanation.
    - Statement of work limitations, license history and sanctions (only required if you are applying to join UnitedHealthcare's Medicare and Medicaid plan(s).
        - Statement should include:
            - Any limitation in ability to perform the functions of the position, with or without accommodations;
            - History of loss of license and/or felony convictions;
            - History of loss or limitation of privileges or disciplinary activity.
        - W-9 Form
        - Hospital staff privileges

    - Insurance
        - Active errors and omissions (malpractice) insurance or a state-approved alternative
        - Malpractice history
    - Other
        - Other credentialing requirements such as AMA profile or criminal history review as required by Credentialing Authorities
        - Notification if this provider has even been a delegated provider to this credentialing application
        - Passing score on state site visit (if required)
- Credentialing for Medicaid and State Programs (Community Plan)
    - State-specific Credentialing and Recredentialing information on how to join the UnitedHealthcare Community Plan network can be found the Care Provider Manual.
- Facilities – Credentialing Requirements

  Each facility must meet the following criteria to be considered for credentialing:
    - Current required license(s)
    - General/Comprehensive liability insurance
    - Errors and omissions (malpractice) insurance
    - Proof of Medicare/Medicaid program participation eligibility
    - Appropriate accreditation by a recognized agency, or satisfactory alternative
    - Centers for Medicare & Medicaid Services (CMS) certification
- Communication to the applicant of its credentialing and recredentialing decision as soon as practical, but no later than forty-five (45) calendar days after the date of receipt of a completed application
- Required to respond to inquiries from applicants regarding status of a credentialing or recredentialing application as follows: (a) provide automated application status updates at least once every 15 days, informing applicant of any missing application materials until application deemed complete; (b) inform applicant within five (5) business days that the credentialing or recredentialing application is complete; and (c) if credentialing or recredentialing application is denied, notify provider in writing and note any and all reasons for the denial.
- When evaluating whether a practitioner's credentialing application is complete, evidence of malpractice/professional liability insurance includes either current coverage or coverage with a future effective date. Credentialing decisions cannot be delayed or denied solely based on the applicant's malpractice/professional liability insurance having a future effective date. If the credentialing application is approved with a future effective date for the malpractice/professional liability insurance that extends beyond the 45-days notice requirement, the contracting entity is allowed to make the effective date for claims submission the same as the effective date of the malpractice/professional liability insurance.
- As long as malpractice/professional liability insurance is effective, the effective

date for billing privileges shall be the next business day following approval of the credentialing application.

- **Rhode Island UnitedHealthcare Community Plan Requirements**
  Physician Assistants who wish to become PCPs shall submit documentation of evidence of a collaborative relationship with a Primary Care Physician, via the "Primary Care Qualifications Attestation.
- How to submit a request for participation

    - Complete a CAQH ProView application and make sure the CAQH applications is update and attested.
    - Submit your request for participation through the RFP portal.
    - You'll be registered in the UHC system
    - You'll receive a confirmation of your participation request within 5 business days.
    - Once UHC receives your credentialing application, you will be sent a contract. Please note: If you are joining a medical group that already has a participation agreement with UHC, you will not receive a contract directly.
- To begin the process of credentialing a new health care professional go to https://uhcprovider.com/join and submit your request for participation.
- Onboard Pro – An intuitive credentialing tool on the UnitedHealthcare Provider Portal. This allows providers to quickly request to add new health care professionals to your tax ID number and group contract. Onboard Pro integrates with CAQH ProView, so you will no longer need to re-enter the same information for UnitedHealthcare.
- Help with One Healthcare ID
    - Call UnitedHealthcare Web Support at 866-842-3278, option 1, from 7 a.m. to 9 p.m. central time, Monday – Friday
- Help with Onboard Pro, Contracts or Credentialing
    - Please email the Network Management Resource team at networkhelp@uhc.com
- Optum ***Physical Health specialist*** will contact a partner who handles credentialing and contracting on behalf of UnitedHealthcare: Optum Physical Health. (Note that alternative medicine providers (CAM) include acupuncturists, naturopaths and massage therapists.)
- To get started, go to **MyOptumHealthPhysicalHealth.com** (or call 800-873-4575). Go to **myoptumhealthphysicalhealth.com/ProviderCredentialingRequest/ProviderCredRequest?id=1**
    - Request for Information – select email subject: I am a health care provider and would like information about joining an OptumHealth physical network
    - Follow the instructions/prompts at the bottom of the page. You'll receive further instructions and an online form to complete.
- Optum does not contract with: MDs, DOs, or other sub-specialties
- Therapy provider practices that share a TIN with an MD, DO, PhD, or DDS
- Providers who share a TIN with a hospital-based entity
- Home health agencies or therapists who perform home visits
- Physical and occupational therapy assistants

- Optum ***Behavioral Health specialist*** will contact Optum Behavioral Health Solutions, which handles credentialing and contracting on behalf of United Healthcare.
- To get started, go to **providerexpress.com** (look under "Our Network" for specific instructions) or call 877-614-0484.
    - Once you've clicked on our network, select the appropriate option (individually contracted clinicians, group practice, etc.)
    - Individual clinicians – select your state to review requirements
    - Follow instructions/prompts located at the bottom of the page. You'll receive further instructions and an online form to complete.
- To learn more about working with Optum Behavioral Health Solutions, go to **providerexpress.com** and select the network for specific instructions
- To find state-specific requirements, go to **providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk.html**
- For more information, contact Optum Behavioral Health Solutions at 877-614-0484
- Contact
    - UHC Portal Registration
        - If you're new to self-service, get started now
        - Register for a One Healthcare ID, by going to the NEW USER registration page.
    - Support
        - For questions about a credentialing or contracting request that are currently in progress, please email networkhelp@uhc.com
        - For questions about access to the UHC Provider Portal, please email providertechsupport@uhc.com or call 866-842-3278, option 1, from 7 a.m. to 9 p.m. CT, Monday – Friday
    - Demographic Updates
        - To learn how to update your provider information (including address, phone number, office hours, areas of expertise, etc.), please visit the Demographics page.
- The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, UnitedHealthcare members will not be referred and/or assigned to you until the credentialing process and contracting process has been completed.
- If you have questions about any of the required items, please review the UnitedHealthcare Credentialing and Recredentialing Plan, specifically:
    - Section 4.2 – Credentialing Criteria/Source Verification Requirements.
    - Section 7.0 = Credentialing and Recredentialing of Facilities
- Network Timeline
    - Complete a CAQH ProView application for review and approval
    - Submit your request for participation through the RFP portal
    - Joining an existing medical group or sign a new contract
    - Create a One Healthcare ID to access the portal
    - Submit claims, check eligibility, request prior authorization and referrals and more through Electronic Data Interchange (EDI)

Aetna – Ryan Benton

- Staffing Shortages
    - Every company in the healthcare industry is experiencing staff shortages, including CVS/Aetna.
    - Staff shortage problems are extended wait times and education issues
    - Providers are encouraged to utilize the online tools available on Availity and Aetna.com
- If you need to call the Provider Services Center, Credentialing Line or another one of our 800 numbers, please ask for the Call Reference # and provider your feedback through Aetna's surveys when possible.
    - The call reference number allows Aetna to review the call, identify when incorrect information has been provided, and educate the Aetna staff to prevent further issues.
- Updated provider relations processes have removed the "middle man" and gets you directly in touch with the experts on enrollment, demographic update and claim issues.
    - Automation in the enrollment and demographic update allows for shorter turnaround time
    - Network staff monitors the enrollment/update, can make changes as necessary.
    - Providers should utilize the Provider Service Center and/or Availity for claims issues before reaching out to the Provider Relations mailbox.
    - Claims cannot be reviewed without a valid call reference number or Availity ticket number
- If a provider wants to join Aetna's network, they must submit a request for Participation via Provider Onboarding Center on Aetna.com
- Provider's CAQH credentialing application needs to be in "Reattestation" or "Initial Application Complete" status and that the provider has authorized Aetna access to it. The Request for Participation form on aetna.com only begins the contracting process. Once contracting is complete, the credentialing process will begin using the information from the CAQH credentialing application.
    - Outdated CAQH credentialing data and not authorizing Aetna access to view credentialing data in CAQH are the most common reasons credentialing is delayed
- Status of the credentialing application can be obtained by calling Aetna's Credentialing Customer Service Line at 1-800-353-1232, select option 3 for a live person between the hours of 8:30 a.m. – 5 p.m. EST.
- Aetna's average turnaround time to complete initial credentialing is 40 days from receipt of a credentialing application (CAQH) to credentialing decision. This time frame does not include contracting or participation linkage. Contracting and credentialing are separate and distinct processes.
- Existing providers making a TIN update within the same state should complete the Update Tax ID form on the *Existing Provider Resources* page on Aetna.com.
- In your request for participation, you can include up to four service locations. If you have more than four locations, once you appear in the Directory, you can go to Availity to add the additional locations.
- All specialties listed on CAQH would be verified through the Credentialing process.

- Aetna's preferred solution for making Provider data updates is to use Availity.
- There is a section on Aetna.com under *Existing Provider Resources* where it directs providers how to submit terminations.
- Call Aetna's Provider Service Center to determine the status of provider enrollments, demographic updates, etc. at *1-800-624-0756 – HMO based and Medicare Advantage plans & 1-888-MD-Aetna (1-888-632-3862) – All other plans*
- Reach out to the New England provider relations mailbox with your Network Manager on CC for questions that Aetna Provider Service Center can not answer or you have an urgent question: newenglandnetwork_ext@aetna.com
- Providers should reach out to the Provider Service Center and Availity to resolve claims issue first
- If the Provider Service Center and Availity do not resolve your issue, please escalate to the New England provider relations mailbox at newenglandnetwork_ext@aetna.com
- Providers must provide call reference # and/or Availity Ticket # for the claim to be reviewed and/or escalated by this team.
- If you have a large list of outstanding claim issues
    - Providers should start off with the Provider Service Center and Availity and provide claim examples for review.
    - If additional review is required, please submit all outstanding claim issues to the New England Provider Relations mailbox on Aetna's standard claim rework spreadsheet. Providers must provide Call Reference # and/or Availity Ticket # for the claims examples to be reviewed and/or escalated by this team.
- Effective 12/1/2022, Aetna has added new claim edits for Commercial, Medicare and Student Health members.
- Also, Aetna has expanded claim edits for E&M services for Medicare members.
- Details are provided on the Availity Provider Portal at Aetna Payer Space → Resources → Expanded Claim Edits
- Effective 1/1/2023, there have been updates made to services requiring precertification for Commercial and Medicare members.
- List of updates provided in OfficeLink
- Availity gives providers the ability to submit precertifications online, lookup a complete list of services that require precertifications (with a breakdown by product), amongst a number of other online features.
- Effective 1/1/2023, Aetna will update their list of pharmacy drugs
- Changes may affect all drug lists, precertification, step therapy and quantity limit programs
- Prior authorizations for drugs can be submitted on Availity, as well as called and/or faxed into our dedicated lines (provided within the OfficeLink)
- Resources on Aetna.com
    - **CPT code Search for Precertification**
    - Clinical Policy Bulletins (Medical, Dental, Pharmacy & Clinical Policy)
    - Provider Education & Manuals
- Availity offers a number of features for our providers, including
    - Eligibility Checks
    - Submit Claims

    - Claim Status
    - Authorization or Referral Requests
    - Access EOB's
    - Upload Medical Records and Supporting Documentation
    - File Disputes and Appeals
    - Submit a Question for Review (Claims, General Questions, etc.
- Monthly webinars are available to all users
    - Working with Aetna on Availity®: System Overview – First Tuesday of every month, from 2:00 PM to 3:30 PM ET
    - Claims Management – Third Thursday of every month, from 2:00 PM to 3:15 PM ET
    - Doing Business with Aetna: New Provider Onboarding Webinar – Second Tuesday and third Wednesday of every month, from 1:00 PM to 2:15 PM ET
- Learn more about Availity using our System Overview on Aetna.com
    - Providers can also call 1-800-AVAILITY (1-800-282-4548)

Medicare – Lori Langevin

- During the COVID-19 Public Health Emergency, information and instructions may change. See US Department of HHS Public Health Emergency.
- It is vital to receive the latest information-take the following steps to ensure access to the latest updates:
    - Sign up for listserv messaging from CMS Listserv and National Government Services Email Updates
    - Routinely check – CMS Current Emergencies webpage & NGS COVID-19 News page
- Modifier CR (Catastrophe/disaster related)
    - Use on professional and outpatient institutional claims
    - CR modifier is not required on telehealth services
    - Mandatory coding for any claim for which Medicare payment is conditioned on the presence of a "formal waiver" including the Section 1135 waiver
    - Used to identify claims that are/may be impacted by specific payer/health plan policies related to a national or regional disaster.
- Modifier CS (Waives cost share 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 E&M services performed when E&M leads to COVID-19 testing. This allows E&M to be paid at 100% of the fee schedule.
- Two additional modifiers for CY 2022 for Telehealth Mental Health Services
    - FQ – A telehealth service was furnished using real-time audio-only communication technology.
        - 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
            - Beneficiary is not capable of two-way audio/video technology
            - Beneficiary does not consent to the use of two-way,

audio/video technology
    - FR – A supervising practitioner was present through a real-time two-way, audio/video communication technology.
- After the PHE, mental health service 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
    - 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 face to face visit for telehealth mental health services may be performed by a clinician's same-specialty, same-group colleague if the original practitioner is unavailable.
- New/Modifications to the Place of Service Codes for Telehealth as of 1/1/2022. Implementation Date of 4/4/2022: Revising the description of existing POS code 02 to other than in patient's home and adding new POS 10 to telehealth provided in a patient's home
- Medicare has not identified a need for the new POS code 10
- Medicare providers should continue to use the Medicare billing instructions for telehealth claims in CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 190
- On or after 3/1/2020 and for the duration of the PHE
    - Bill audio or audio/video telehealth service with modifier 95 (professional telehealth service from a distant site)
    - POS equal to what it would have been (if services were performed face to face) in the absence of a PHE
    - CR modifier not required on telehealth services
    - Telehealth services are professional services billed as distant site
- CPT 99441 – 99443
    - Telephone E&M service by a practitioner or qualified health care professional
    - 4/30/2020 added to telehealth services; use modifier 95
    - Physicians (including Osteopaths, Podiatrists and Optometrists), Dentists, NPPs (including NP, CNS, PA, CNM) and Maxillofacial Surgeon
- CPT 98966 – 98968
    - Telephone assessment and management service
    - Not on the CMS list of telehealth codes
    - Clinical Psychologists, PT/OT/SLP, Optometrists, NPPs (including NP, CNS, PA, CNM), LCSWs, RDs and Nutrition professionals.
- Telehealth Documentation
    - Time-based services, document start/stop time or total time
    - Teaching physician may use audio/video telecommunications during key portions of service
    - Same as any face to fac 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
- Provider Enrollment – Top Development Reasons
    - Part B Paper
        - Completed Signature
        - Initially enrolling groups, voided checks or bank letter for the CMS-588 and or EFT, LBN, NPPES does not match IRS document
        - EFT corrections or missing information
        - Physician/nonphysician wrong specialty type selected
        - Incorrect AO/DO signer on the CMS-855B and the CMS-855R
        - Supporting documentation; nonphysician certifications/degree, IRS document, voided check/bank letter
    - Part B Web
        - Completed Signature
        - Initially enrolling groups, voided check or bank letter for the CMS-588 and or EFT, LBN NPPES does not match IRS document
        - EFT corrections or missing information
        - Incorrect AO/DO signer on the CMS-855B and the CMS-855R
        - Supporting documentation; nonphysician certifications/degree, IRS document, voided check/bank letter
        - Missing dependent application: (i.e., 855I or 855B for Sole Owners)
- CMS issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule, and other Medicare Part B issues, effective on or after 1/1/2023
- The 2023 PFS proposed rule is one of several proposed rules that reflect a broader administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability and innovation
- See Reference: Calendar Year (CY) 2023 Medicare Physician Fee Schedule Proposed Rule | CMS

- No Surprises Act Protects consumers from surprise medical bills
- Requirements are referred to as “No Surprises” rules
- Prohibits balance billing in certain circumstances
- Requires disclosure about balance billing protections and transparency around health care costs
- Provides consumer protections related to continuity of care and establishes requirements related to provider directories
- Resources: Provider Requirements and Resources
- Questions: provider_enforcement@cms.hhs.gov

- National Government Services shall issue decision on Redeterminations within 60 days.
- If you have not heard, please do not resubmit another request
- Submit one redetermination request for all lines in question on a claim
- If you're a current NGSConnex user, you can check the status of your appeal at https://www.ngsmedicare.com/NGS_LandingPage/
- Please do not submit the appeal via paper and NGSConnex
- Un processable claims will reject and have denial code MA130
    - MA130 denial: Claim contains incomplete/invalid information
        - No appeal rights – claim unprocessable
        - No reopening rights
        - Claim must be resubmitted as a new claim
        - Do not indicate corrected claim
        - Do not appeal
- For appeals to be processed Medicare must have the beneficiarys name, Medicare number, date(s) of service and item/service that is the issue.
- Ensure all items are completed
- If there is not enough room on the form, please include an attachment that details the required information.
- If there is insufficient information with your appeal request, it may be dismissed
- If you are submitting your appeal past the time limit, please include an explanation for the delayed request
- Include all medical record documentation that supports your request
- The medical record documentation must be legibly signed and dated by the physician.
- To avoid denials, verify all data pertaining to the service is correct.
    - NPI of billing physician/rendering physician
    - Assignment or nonassignment of claim
    - Beneficiary's Medicare number
    - Zip code of the place of service
    - All related diagnosis reported with the highest degree of specificity
    - NPI of referring physician
    - Date of service/place of service
    - Procedure code
    - Modifiers when applicable
    - Number of service(s) and billed amount for each service
    - CLIA number for laboratory services
    - The last visit date, x-ray date, initial treatment date for podiatry, physical therapy and chiropractic services
    - Primary payer data
    - Use of appropriate modifier with the scenario
        - Service of procedure has both a professional (26) and technical component (TC)
        - Duplicate service or procedure was performed by more than one physician (77)
        - Only part of a service was performed (54 or 55)
        - Bilateral procedure was performed (50)

- Modifier 76 – duplicate service or procedure was provided by the same physician
    - Document a repeat or duplicate service to reflect it is a distinct and separate service. (Failure to document a repeat or duplicate service will result in a denial)
    - Report clarifying information pertaining to repeat or duplicate procedure using Item 19 of the CMS-1500 claim form or in the Extra Narrative Data segment (Loop 2300/2400) of the ANSI ASC X12 837 version of an electronic claim. Utilize this field to report the time of each subsequent or repeat service or the number of times this service is needed to be performed.
- Report body site modifiers to indicate more than one of the same services is performed but on different body parts/sites, e.g., LT, RT, TA, T9
- Report modifier 59 to indicate a distinct procedural service
    - This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)
- Modifier 22 is for service or procedure has been increased
    - Represents increased procedural services
    - The work required to provide a service is substantially greater than typically required
    - Documentation must support the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)
- Modifier 52 is for a service or procedure that has been reduced
    - Represents reduced services and when under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion
    - Explanation can be submitted by entering the information in Item 19 (CMS-1500 form) or in the Extra Narrative Data segment (Loop 2300/2400 of an electronic claim) or submitting the supporting documentation

- Unlisted Procedure Code – enter description of an unlisted procedure code (NOC code) or a "not otherwise classified" code
    - Failure to describe the NOC will result in a denial
    - Information must be entered into Item 19 of the CMS-1500 claim form or in the Extra Narrative Data segment (Loop 2300/2400) of an electronic claim
- Use the link for NOC code instructions: https://www.ngsmedicare.com/web/ngs/billing?selectedArticleId=4096942&lob=96664&state=97178&region=93623&rgion=93623
- Item 19 is also used to describe other billing scenarios as follows
    - Enter the drug name and dosage
    - Enter all applicable modifiers when modifier 99 (multiple modifiers)

are entered
    - Enter the statement "Testing for hearing aid" when billing services involving the test of a hearing aid(s) is used to obtain intentional denials when other payers are involved
    - When dental examinations are billed, enter the specific surgery for which the exam is being performed
    - Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them
    - Enter the date for a global surgery claim when providers share postoperative care
- Comply with requests for supporting documentation
    - Failure to comply with the request with result in a denial
    - NGS may solicit for more information from the provider by issuing an ADR
    - We will specify in the ADR the documentation that is needed to make the coverage or coding determination
    - Responses to ADRs should be received within the 45-day timeframe
    - We will complete the review within 60 days of receiving all requested documentation and notify the provider of the claim determination
    - Record of documentation requests where no timely response was received will result in a denial indicating denial was made without reviewing the medical record
- Supporting documentation must include an acceptable signature
    - Must include rendering physician's signature
    - Failure to provide valid signature will result in a denial
    - Medicare contractors require a legible identifier for services provided or ordered
    - Only acceptable method of documenting provider signature is by written or electronic signature or attestation or signature log
    - Stamped signatures are not acceptable
        - CMS will permit the use a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability
- When Medicare is the secondary payer, the claim must include information from the primary insurer
    - Failure to include this information will result in a denial
    - To submit MSP claim using the CMS-1500 claim form, refer to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf
    - To submit MSP claims electronically, refer to Medicare Secondary Payer Manual for Electronic Submitters/ANSI Specifications for 837P
    - Obtaining primary insurance information from the beneficiary is the provider's responsibility

        - Claim filing extensions will not be granted because of incorrect insurance information
    - Make sure you use to correct form for appeal submissions
        - Part B Appeals Request form: Redetermination: First Level of Appeal
    - If your request is regarding general information, please send a letter with your specific questions
    - Not all claim determinations can be appealed or corrected
        - If your claim has the MA130 group reason code on the provider remittance, the claim must be resubmitted with the complete/correct information
- Reference PTAN number; not NPI number on redetermination form
- Include ICN for Part B claim in question on redetermination form
- Submit one redetermination request for all lines in question on the claim; do not submit a redetermination form for each individual line of the claim
- Submit one redetermination form per claim; do not submit one redetermination form for multiple claims
- If using NGSConnex to submit a request, do not also mail your request
- Do not submit the same appeal multiple times via NGSConnex

AllWays Health Partners – Yesenia Fajardo

- AllWays Health Partners will change its name to Mass General Brigham Health Plan to reflect and advance the system's shared mission to improve health outcomes, reduce costs, and transform the healthcare experience.
- The change will take effect Jan. 1, 2023.
- Under the new name, AllWays Health will continue to maintain and grow the strong network of providers, including those outside of the Mass General Brigham system.
- Please visit our REBRAND PROVIDER FAQ for the latest information about our new name.
- Membership Insights for the Third Quarter of Fiscal Year 2022
    - Total Membership – 264,900
    - Commercial – 220,953
    - MassHealth – 43,947
- Expanding within New England: Year to date growth
    - Massachusetts – 6.83%
    - New Hampshire – 11.66%
    - Rhode Island – 8.74%
- There are two federal changes that impact the health care industry, effective January 1, 2022: the No Surprises Act (as part of the Consolidated Appropriations Act of 2021) and the Transparency in Coverage rule. Both directly apply to commercial and self-insured coverage.
- The No Surprises Act has many touchpoints on the provider community, including no surprise billing, updated member ID cards, and provider directory changes.
- **Balance Billing Members:** The No Surprises Act protects members from 'balance billing' for three specific scenarios:
    - Emergency Room Care

    - Professional services rendered by a non-Participating provider during admission at a Participating Facility
    - Air Ambulance transportation
- **Member ID cards:** To help members better understand their cost-sharing responsibilities, plans will update their ID cards in the new year to reflect their in-network and out-of-network deductible—and their maximum out-of-pocket requirements.
- **Provider Directory:** Health plans will be required to verify provider directory information every 90 days and remove providers from directories if unable to validate.
- **Advance Explanation of Benefits (AEOB):** To keep patients informed prior to certain services, a member will be able to request a pre-service cost estimate after scheduling a service with their provider.
- Please visit Transparency & Regulations - AllWays Health Partners for additional information regarding No Surprise Billing Act.
- Allies and Allies Choice HMO continue to grow with the addition of Salem Hospital and South Shore Health and Harbor Medical Associates
- Starting on **November 1st,** this high-performance network product will be offered to small and large groups within the South Shore Health system service area. The offering will feature South Shore Hospital PCPs and specialists—in addition to those at Newton-Wellesley Hospital—to provide world-class care and an exceptional customer experience at lower costs.
- Members must select a PCP from South Shore Health, SSH IDN, Harbor Medical Associates, Newton-Wellesley Hospital or Salem Hospital
- Mass General Brigham Employee Plan reminders that there can be a difference in cost sharing between the Select and Plus PPO
    - Check the member's card
    - Check the member's information on the provider portal
- My Care Family ACO reminders
- ACOs are integrated clinician systems that consist of PCPs and other clinicians that will work to better coordinate patient care
- My Care Family offers complete care and coverage through MassHealth by Greater Lawrence Family Health Center, Lawrence General Hospital, and AllWays Health Partners.
- Member eligibility is limited to the Merrimack Valley Region
    - Haverhill
    - Lowell
    - Lawrence
- AllWays Health Partners is pleased to announce that, under our new name, we will offer our first-ever Medicare Advantage products – also on January 1, 2023. This will give us the opportunity to support a growing population with a broad range of healthcare needs.
- For more information, please visit the Medicare Advantage Provider Page, as this will be updated on an ongoing basis with the latest information available.

- Plans to be offered in select Massachusetts counties:
    - Bristol
    - Essex
    - Middlesex
    - Norfolk
    - Plymouth
    - Suffolk
    - Worcester
- Provider Enrollment: New Group/Provider
- Provider Enrollment receives information for New Groups and Providers
- All documentation must be complete before enrollment can begin the process
- Demographic and Affiliation information is entered
- Group/Provider is entered and completed into the systems with an assigned effective date
- An effective date cannot be assigned until all affiliated providers have been through the credentialing process.
- To ensure applications are processed timely, the follow documentation is required to ensure accurate entry and verification of New Providers and Groups
    - Provider Enrollment
        - Provider HCAS/Roster
        - Signed W-9
        - Clia Waiver (If applicable)
        - Ethnicity Form
        - Signed Contract Agreement
    - Credentialing
        - Active License
        - Federal DEA (If applicable)
        - Board Certification (If applicable)
        - Malpractice/Liability Insurance
        - Completed CAQH Profile & CAQH ID
        - Certificate of Accreditation or Survey (For Facilities)
        - Federally Required disclosures (For Facilities)
- Once Enrollment has started the process, a New Provider is sent to Credentialing. AllWays Health Partners delegates the Primary Source Verification (PSV) to Andros Technologies for Credentialing requirements**.**
- Once a provider has completed PSV, they are reviewed for any sanctions against licensure or actionable reports
- The AllWays Health Partners Credentialing Committee will approve or deny credentialing based on the results of the PSV and return completed to the Credentialing team.
- Providers that do not meet credentialing requirements are reviewed by the Committee comprising of various provider types to determine next steps
- Upon return an effective date will be provided and the process is completed in the system to finalize enrollment.
- Provider CAQH Profiles must be completed and accurate in order to verify information for credentialing. Expired attestations or conflicting information will result in delays.

- The Provider Enrollment Portal gives you online access to submit the following transactions for your practice:
    - Affiliate a new doctor : Enrollment and Credentialing submissions can take a minimum of 45 days to be fully processed. Please remember to review your site/practice roster prior to inquiring on a status request.
    - Download a completed HCAS form
    - Open or close a panel
    - Terminate an affiliation: For providers terminating from a practice, AllWays Health Partners requires written notification at least 60 days prior to the practitioner's termination date unless otherwise agreed upon.
    - Submit demographic changes to AllWays Health Partners – Continue to run provider rosters and regularly review our Provider Directory information.
- Prior Authorization Submission Process: When submitting a prior authorization and if criteria is not met, or partially met, the authorization will pend for UM review. In this instance additional clinical information is required.
    - Clinical documentation can be submitted by two different methods
        - Upload directly to the authorization. (*user guides provide a step-by-step on how to upload*) allwayshealthpartners.org/providers/authorization-guidelines
        - Fax using the required fax cover sheet within our Provider Portal. Faxcoversheet.pdf (allwayshealthpartners.org)
        - Please Note - Not submitting clinical documentation may result in an administrative denial
- Verifying prior authorization requirements can be completed on the Provider Portal homepage, you will be able to access the new auth requirements tool-CODE CHECKER. Validate requirements by code
- Prior authorization enhancements provider.allwayshealthpartners.org/prior-authorization-2020
- Prior authorization information page allwayshealthpartners.org/providers/authorization-guidelines
- New electronic payment options as of January 2022
    - **Virtual Credit Card**: Providers who are not currently registered to receive payments electronically will be automatically enrolled in this new payment option.
    - **Electronic Funds Transfer**: To sign up for EFT payments, you will need to enroll through the ECHO Provider EFT/ERA Enrollment.
    - **Medical Payment Exchange**: If you are not enrolled to receive payments via EFT, you opt out of the virtual credit card, and you have enrolled for MPX with another payer, you will continue to receive your payments in your MPX portal account.
    - **Electronic Remittance Advice (ERA) / 835 files -** Providers can now access their ERA (835 files) from their designated clearinghouse or by enrolling through the ECHO Provider EFT/ERA Enrollment.
    - **Explanation of payment (EOP):** EOPs have a new look and feel! These improved EOPs will combine payment information, instructions, and remittance data in a single document.
    - For more details: Visit the resource page
- AllWays Health Partners is pleased to announce a partnership with Lyra Health to

offer a new, comprehensive solution for AllWays members that will expand the availability of high-quality mental health services and promote overall health and well-being.

- Features include: Fast access to appointments, personalized navigation, and comprehensive care options.
- Lyra will be rolled out in phases beginning June 2022
- To learn more about the many resources currently offered to help members get the mental health and substance use support they need, please visit allwayshealthpartners.org/members/behavioral-health.
- Our public site has important information and resources for providers, such as:
    - Medical Policies
    - Payment Policies
    - Provider Manual
    - Provider Directory
    - Drug Lookup
    - Forms
    - Authorization guidelines
    - also have a dedicated Provider Education page: https://provider.allwayshealthpartners.org/education
- AllWays Health Partners' provider portal is your one-stop-shop for managing your AllWays Health Partners patients. allwaysprovider.org
- Through the portal, you have real-time access to:
    - Verify patient eligibility
    - Verify claims status
    - Submit or check authorizations/referrals
    - Access your explanation of payments (EOPs)
    - View member and provider roster reports
    - Update your practice information
    - And much more
- allwayshealthpartners.org/providers/claims-information
- Highlights:
    - Clear guidance for where to send claims
    - ID card images to help you identify plans
- Contacts:
- Claims status, eligibility, EOP – Provider portal: allwaysprovider.org
- Claims issues, benefits – Provider customer service: 855-444-4647 or providerservice@allwayshealth.org
- Portal IT Support – prweb@allwayshealth.org
- Provider enrollment and credentialing, directory issues – Provider Enrollment & Credentialing: pec@allwayshealth.org
- Medical policies, payment policies, provider manual, provider directory, drug lookup, forms – Public Site: allwayshealthpartners.org/provider
- Audit denial inquiries – Audit Team: audit@allwayshealth.org
- Additional Tools & Resources
    - Provider Newsletter Admin Newsletter Archive (allwayshealthpartners.org) which speaks to Rebranding and Medicare Advantage
    - New Provider Blog regarding Rebranding and Medicare

Advantage Providers, here's what to expect in the next few months (allwayshealthpartners.org)
    - Medicare Advantage lading page- Medicare Advantage FAQ for Providers (allwayshealthpartners.org)
    - Rebranding FAQ Mass General Brigham Health Plan Provider FAQ (allwayshealthpartners.org)
- Visit provider/allwayshealthpartners.org/manage-subscription to register
    - Administrative Newsletter – Monthly updates that make it easier for your practice to do business
    - Clinical Digest Newsletter – Read the top clinical and patient care information
    - Best Practice Provider Blog – twice per week you can get the latest in health and health insurance trends, news and tips
    - Provider Community – Live new way for providers to connect with AllWays and their peers to share feedback and have a dialogue

Blue Cross & Blue Shield of Rhode Island – Stef Vito

- BCBSRI continues to follow the governors executive order regarding making any telemedicine updates.
- BCBSRI current Telemedicine policy is still in effect with no changes.
- COMMERCIAL
    - Telemedicine is covered at 100% of the in-office visit
    - Code 99211 & 99212 continue to be covered with no member cost share for primary care including advanced practitioners and behavioral health psychiatrists and clinical nurse specialists.
- MEDICARE
    - All codes and services will apply the appropriate member cost share under their benefit plan.
    - Any changes to these policies will be communicated via this forum, Provider Update, email blast and our Alerts & Updates section of the provider portal.
- No Surprise Billing Law - When member's receive emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, they are protected from surprise billing or balance billing.
- BCBSRI claim system is updated with surprise billing overrides. When we receive a member claim where they are receiving inpatient services by a nonparticipating provider in a network hospital, the claim will automatically pay as in-network and pay to the provider.
- Credentialing Process – How to become a Participating Provider with BCBSRI?
    - Step 1: Navigate to the "Providers" webpage on bcbsri.com
    - Step 2: Select "Become a participating provider" on the side navigation pane
    - Step 3: Fill out the general and primary practice information
        - The credentialing contact is the point of contact for the contract and any missing forms/information needed.
    - Step 4: Fill out your mailing address information
        - If your mailing address is the same as your primary location, you can check off the check box "Same as physical address"

    - Step 5: Fill out "New Provider" information
        - This information is similar to your general information in Step 3, but this will be produced on your contract and defines your specialty
    - Final Step: Answer the handful of questions on the form, once you have answered each question, you can hit the "SUBMIT" button.
- Database Credentialing Team will review your application and send an informational packet with forms to be completed.
- Return the completed forms to the sender. The Database Credentialing Team will then send the application and paperwork to Aperture.
- Aperture is a BCBSRI vendor responsible for completing primary source verification for credentialing. Once Aperture completes their review, the credentialing file is sent back to BCBSRI.
- BCBSRI will issue a decision regarding the credentialing application with 45 days of completed application.
- The effective date with BCBSRI is the date AFTER the Credentialing Committee determines approval. Example: If the Committee meets and approves the application on 9/1/2022, your effective date is 9/2/2022.
- Enrolling a new provider to an existing practice – If the provider is already participating with BCBSRI, the office will need to submit a Practitioner Change Form with all the necessary information related to the change.
- The Practitioner Change form can be found on the forms page and can be faxed or emailed to the Provider Database Team.
    - Step 1: Navigate to the "Providers" webpage and BCBSRI.com
    - Step 2: Select "Forms" on the side navigation pane
    - Step 3: Select Practitioner Change Form
- **Credentialing-** currently BC does not have any back log or delays with new provider credentialing applications. As a reminder, anyone who is submitting the credentialing application should be using their email address for contact purposes. When the new application is submitted the submitter should monitor their e-mail to ensure they are receiving the updates from our Credentialing Team. There are times the information can fall into your spam or junk folder.
- **Provider Call Center-** BCBSRI provider call center has met Service Level goals last year and is also on track to meet them this year. The Provider Call Center is based in Manila, Philippines, and has been able to offer employees the opportunity to work remotely, which has helped to address some of the challenges brought about by the pandemic.
- The provider call center does experience peaks associated with the normal business cycles and handles those higher volume periods with flexible and dynamic use of staff resources. For example, during peak call volume hours, the Support team take calls as needed. The approach is to closely monitor and manage call volume and customer needs, making quick adjustments throughout the day.
- BCBSRI's focus is to help Providers get the information they need quickly and easily using technology tools, such as an Interactive Virtual Assistant, use of the Provider Web Portal and other solutions.
- BCBSRI asks providers to remember to fill out a Practitioner Change Form (or update on the provider portal) if the following changes are being made with your office:
    - TAX ID change

    - Mailing and/or payment address for existing office
    - Closing existing site
    - Opening new site or joining existing practice (must use PCF – not provider portal)
    - Change in office hours, covering physicians and accepting/not accepting new patient's
- Please note when a provider leaves a location or if a location is closed, an effective date of the change is needed on the Practitioner Change Form, or the date can be left in the "note" section of the provider portal data verification page. **Claims will continue to pay based on the date of service even if the location is terminated.**
- Practitioner Change Forms are located at bcbsri.com > Providers > Forms. All Practitioner Change Forms can be faxed to 401-459-2099 or emailed to ProvDB@bcbsri.org.
- If you need assistance with filling out the form, please feel free to reach out to your Provider Relations Representative.
- Attesting to your provider data on a quarterly basis is a CMS and BCBSRI regulatory requirement
    - Starting on 1/1/2022 Quarterly Data Attestation is a requirement under the Federal Consolidated Appropriations Act (CAA) legislation
    - Providers who did not attest to their information in quarter 3, have been excluded from the BCBSRI provider directory- Find a Doctor Tool. Any provider removed from the Provider Directory would have received a notification from BCBSRI on 10/1/22.
- Quarterly Data Attestation can be done on **bcbsri.com** provider account under **"Update Practice Info"**
- Having updated provider data is extremely important for both the member and provider. The quarterly data attestation includes confirming practice location, phone number and accepting new patients' status, etc.
- If you need help setting up a bcbsri.com provider account, adding providers to an existing account, or accessing and submitting the quarterly data attestation form please contact: providerdirectory@bcbsri.org
- BCBSRI invites you to join them the second Tuesday of every month from 10:00am-11:00am for a conference call with the Director of Provider Relations, who will provide updates and reminders on specific topics of that month.
- Topics of discussion are:
    - Telemedicine Policy Reminders
    - Referring to non-participating providers/labs
    - 2023 Updates
    - Provider data reminders
- If you or anyone in your office does not receive BCBSRI email blasts for important updates and monthly conference call invites, please have them email ProviderRelations@bcbsri.org.
- Every first of each month, BCBSRI post important updates from many of our Departments within BCBSRI like:
    - Behavioral Health
    - Quality (HEDIS)
    - Medical Policy
    - Provider Relations

    - Pharmacy
- Matthew Collins, M.D., M.B.A. is BCBSRI's executive vice president and chief medical officer, creates a column monthly on important topics within the medical area. His columns can be found under "A word from Dr. Collins."
- The Provider Update can be found on our Provider Page, under Provider Update

2023 CPT Changes – Nancy Enos

- Please see the attached Coding Cheat Sheet distributed to attendees by Nancy.
- Any additional information or training being request about this information can be directed to Enos Medical Coding at 401-301-2769