NEWSLETTER

CORNERSTONE ALLIANCE, INC.

SEPTEMBER 2017

CREDENTIALING INFORMATION

In order to notify the payers in a timely manner, please submit **ANY** demographic changes that have taken place within your office. All demographic changes must be submitted to Cornerstone in a written format. Failure in doing so could result in claim denials. Examples of such demographic changes are:

- *Primary, Alternative or Remit Address changes*
- *Adding/Deleting Alternate Locations*
- *TIN Number and Group Name Changes*
- *Medicaid Number Once Received (If applicable)*

Please fax all demographic changes to Cornerstone at (419) 226-9889, Attn: Anita or Melita. If you have any questions regarding the above information, please contact Anita at (419) 996-5389 or ajdumm@mercy.com or Melita at (419) 996-5314 or MRBellman0@mercy.com.

FEE SCHEDULE UPDATES

On August 15th, there was an update to the Cigna fee schedule. For fee schedule information, please email Mechele Fischer, Financial Analyst, at mlfischer@mercy.com.

IN THIS ISSUE...

- **Credentialing Information**
- **Registration Form for Risk Management Seminar**
- **Claims Resolution Process**
- **Aetna Precertification List Update**
- **Anthem's Genetic Testing Program FAQs**
- **Anthem Network eUPDATE—Notice of changes to Prior Authorization requirements**
- **CareSource Dual Eligible Special Needs Plan (D-SNP)**
- **Credentialing Provider List**
- **Cornerstone Staff**

2017 EDUCATION EVENT SCHEDULE

- October 11th Risk Management Seminar sponsored by Huntington Insurance and Medical Protective

Two topics will be presented with 1 AMA PRA Category 1 Credit available per topic.

1. ***Fraud, Abuse, & Waste, Oh My! Developing an Effective Compliance Program***
2. ***Meeting the Challenge: Managing Difficult and Noncompliant Patients***

Registration Form

Wednesday, October 11, 2017

7:00 AM—9:00 AM

St. Rita's Auxiliary Conference Center, Room #2

Provider Office: ____

Name(s):

____

____

____

Email Address (Please provide so confirmation can be sent that registration form was received):

____

____

____

Phone Number: ____

Please email or fax to Jenifer Stegaman, Provider Relations & Education Specialist by:

<u>Tuesday, October 3, 2017</u>

jstegaman@mercy.com or (419) 226-9889

CLAIM RESOLUTION PROCESS

IF YOU ARE HAVING CLAIM ISSUES AND WOULD LIKE ASSISTANCE FROM CORNERSTONE ALLIANCE TO HELP IN GETTING THESE RESOLVED, PLEASE FOLLOW THE STEPS LISTED BELOW BEFORE CORNERSTONE IS ABLE TO STEP IN. THIS MUST BE DONE BEFORE A CLAIM ESCALATION CAN BE MADE OR THE PAYER WILL DENY THE CLAIM ESCALATION AFTER IT SITS WITHIN THAT DEPARTMENT FOR SEVERAL WEEKS TO MONTHS.

- Call the Customer Service number that is located on the back of the patient's insurance card;
- Request to speak to a supervisor;
- Get a reference number for that call;
- Submit to Jeni Stegaman, Provider Relations & Education Specialist by either fax at (419) 226-9889 or email at jstegaman@mercy.com:
  - Reference Number
  - Patient Insurance Card
  - Claim Denial
  - Copy of the claim form
  - Copy of the EOB

Important information for your office

As published in the September 2017 Aetna OfficeLink Updates™

September 1, 2017

Updates to our Participating Provider Precertification list

These changes will take effect as noted below.

Reminders and updates
We encourage you to submit precertification requests at least two weeks before the scheduled services. Effective January 1, 2018, the following precertification changes will apply:

- We'll require precertification for two new drug classes:
  - Amyotrophic lateral sclerosis (ALS)
  - Chimeric antigen receptor T (CAR-T) cell therapy

We won't require precertification for artificial lumbar disc surgery or cervicoplasty procedures or for interferon drugs used to treat hepatitis C:

- Pegasys
- Peg-Intron
- Intron A
- Infergen

The following new-to-market drugs require precertification:

- Bavencio (avelumab) — precertification effective May 26, 2017. This drug is included in the PD1/PDL1 inhibitor drug class.
- Brineura (cerliponase alfa) — precertification effective July 20, 2017. This drug is included in the enzyme replacement drug class.
- Imfinzi (durvalumab) — precertification effective July 7, 2017. This drug is included in the PD1/PDL1 inhibitor drug class.
- Kevzara (sarilumab) — precertification effective July 1, 2017. This drug is included in the immunologic agents drug class.
- Ocrevus (ocrelizumab) — precertification of the drug and site of care effective May 23, 2017. This drug is included in the multiple sclerosis drug class.
- Radicava (edaravone) — precertification of the drug and site of care effective July 20, 2017. This drug was added as an independent drug but will move to the ALS drug class on January 1, 2018.
- Siliq (brodalumab) — precertification effective July 1, 2017. This drug is included in the immunologic agents drug class.
- Tymlos (abaloparatide) — precertification effective July 1, 2017. This drug is included in the osteoporosis drug class.

You can find more information about precertification under the "General information" section of the NPL at **aetna.com/health-care-professionals/precertification/precertification-lists.html**.

0000015

Clinical payment, coding and policy changes

Notice of Material Amendment to Contract

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment. In developing our policies, we may consult with external professional organizations, medical societies and the independent Physician Advisory Board, which advises us on issues of importance to physicians. The chart below outlines coding and policy changes.

Procedure	Effective date	What's changed
Modifier KL: DMEPOS item delivered via mail*	September 1, 2017	We allow payment of KL only when billed with A4233, A4234, A4235, A4236, A4253, A4256, A4258 or A4259. Modifier KL should be appended only to diabetic supplies that are ordered remotely (by phone, email, Internet or mail) and delivered to a member's residence by common carriers (for example, U.S. Postal Service, Federal Express, United Parcel Service) and not with items obtained by members from local supplier storefronts.
Breast pump supplies	August 1, 2017	We do not cover the following breast pump–related supplies/accessories: bottles that are not specific to breast pump operation, including the associated bottle nipples, caps, lids and locking rings. In addition, covered breast pump replacement supplies are limited to the purchase of one unit per item per rolling 12 months where a covered female would not qualify for the purchase of a new pump. Additional breast pump tubing, adapters and shields or similar equipment purchased or rented for personal convenience or mobility are not covered. For more information, refer to Clinical Policy Bulletin 0421: Breast Pumps at **aetna.com/cpb/medical/data/400_499/0421.html.**
Correct coding of hospital observation, critical care, admission and discharge services*	December 1, 2017	We'll limit coverage for these hospital professional services to one time per day, per patient, across all providers: *Hospital observation services (99234 – 99236) *Critical care services (99291 – 99292) *Hospital admission services (99221 – 99223) *Hospital discharge services (99238 – 99239) This payment policy is in line with CMS guidelines.
Non-physician assistant at surgery reimbursement*	September 1, 2017	We're retracting a communication published in the June issue of OfficeLink Updates. We told you that we'll pay a non-physician assistant at surgery based on the provider type effective September 1, 2017 — that is, we'll pay multiple surgical procedures billed with any assistant surgeon modifier at 12 percent for the first procedure with the highest relative value units (RVU), 6 percent for the second procedure with the second-highest RVU and 3 percent for each subsequent procedure. **We are not changing our current payment methodology for non-physician assistant surgery at this time.**

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Changes to commercial drug lists begin on January 1, 2018

On January 1, 2018, updates will be made to our Pharmacy Management drug lists. Starting on **October 1, 2017**, you can view the list of upcoming changes at **aetna.com/health-care-professionals/clinical-policy-bulletins/pharmacy-clinical-policy-bulletins.html**.

Reminder: Starting October 1, 2017, safety edits will be added to opioid drugs to help with overprescribing.

Want to select a preferred drug for your patient from your cell phone? Our commercial formulary is available for mobile devices. Just go to the App Store and type in "Formulary Search" — then download the Formulary Search app for free.

You can also search at **www.formularylookup.com.** Enter the drug name, state and channel (plan type). Then under "Payer/PBM," select "Aetna Inc." to view the drug coverage information. At the bottom of the page you can select "Get it on Google Play" or "Download on the App Store" to access this information on your phone.**

** Google Play and the Google Play logo are trademarks of Google Inc. App Store is a service mark of Apple Inc., registered in the U.S. and other countries.

The changes will affect all Pharmacy Management drug lists, precertification, quantity limits and step-therapy programs.

Ways to request a drug prior authorization:

- Call the Aetna Pharmacy Precertification Unit at **1-855-240-0535.**
- Fax your completed **Prior Authorization Request Form** to **1-877-269-9916.**
- Submit your completed request form through our **secure provider website.**

For more information, call the Aetna Pharmacy Management Provider Help Line at **1-800-AETNARX.**

Important pharmacy updates

Medicare

Visit **aetnamedicare.com/en/prescription-drugs/check-medicare-drug-list.html** web page to view the most current Medicare plan formularies (drug lists) and Clinical Policy Bulletins that we update at least annually. For a paper copy of the formularies and bulletins call **1-800-414-2386.**

Commercial

Notice of changes to prior authorization requirements

Visit **aetna.com/health-care-professionals/clinical-policy-bulletins/pharmacy-clinical-policy-bulletins.html** to view:

- Commercial Pharmacy plan drug guides with new-to-market drugs that we add monthly.
- Clinical Policy Bulletins with most current prior authorization requirements for each drug.

Note: To review the September 2017 OfficeLink Updates online to link to all information in this flyer, go to aetna.com. Click on "Health Care Professionals," then under "Resources for Health Care Professionals" click on "Newsletters and News."

This material is for informational purposes only and contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of health care services. While this material is believed to be accurate as of the print date, it is subject to change.

The information and/or programs described in this newsletter may not necessarily apply to all services in this region. Contact your Aetna network representative to find out what is available in your local network. Application of copayments and/or coinsurance may vary by plan design. This newsletter is provided solely for your information and is not intended as legal advice. If you have any questions concerning the application or interpretation of any law mentioned in this newsletter, please contact your attorney.

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tA-15808 - 082217

Procedure	Effective date	What's changed
Home sleep studies	June 1, 2017	In March, we told you that we would limit home sleep studies to 1 time per 7 days and 2 times per 365 days. We changed that decision to allow home sleep studies 3 times per 365 days. This change was effective June 1, 2017.
Neuromuscular junction testing with intraoperative neurophysiology monitoring	December 1, 2017	We will no longer allow code 95937 when billed with codes G0453, 95940 or 95941. Modifier 59 will not override this edit.
Assistant surgeon	December 1, 2017	We're retracting a communication published in the March issue of OfficeLink Updates. We told you that we were adding more procedure codes to our assistant surgeon list effective June 1, 2017. **We are not changing our current assistant surgeon list at this time.**
Reminder for readmissions payment policy	Reminder	As a reminder of our readmissions payment policy: We will not recognize and reimburse another DRG payment for any member readmitted to the same facility within 30 calendar days of a prior stay when related to the prior stay's medical condition. This includes evaluation and management of that condition. We consider the subsequent admission included in the original DRG payment for the initial admission. This policy applies to any facility reimbursed at a DRG case rate.
Pass-through billing*	October 1, 2017	In June, we told you that starting September 1, 2017, we'll deny pass-through billing for most lab charges from a facility or a non-facility provider. The effective date will now be October 1, 2017. The provider that performs the tests must bill for these services. We'll pay for pass-through billing during an inpatient hospital admission. We'll also pay facilities for pass-through billing for members receiving outpatient services at the facility when the specimen collection occurs at the facility on the same day as other services. We don't reimburse for specimen collection.

* Washington state providers: This item is subject to regulatory review and separate notification.

Management and Network Services LLC (MNS) contract ends January 1, 2018

Effective January 1, 2018, MNS won't be a contracted provider. It will no longer coordinate the skilled nursing services for credentialing or manage authorizations or claims payments. This change impacts all patients enrolled in Aetna and/or Coventry Medicare, commercial or network access business (First Health®, auto or workers' compensation) lines of business.

Send future claims submissions electronically or by mail

For dates of service on or after January 1, 2018, please submit all patient claims directly to Aetna and/or Coventry. Just check the back of the member's ID card for the correct address or claim-payer ID number.

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Anthem. BlueCross BlueShield

Anthem's Genetic Testing Program FAQs

Q: What services are included in the Anthem Genetic Testing Program?
A: Effective July 1, 2017, AIM Specialty Health® (AIM) will perform the medical necessity review of all genetic testing services for Anthem's local fully insured members. AIM will review pre-authorization requests for genetic tests against health plan clinical criteria.

Q. Will AIM review genetic counseling as part of its medical necessity review of a genetic test?
A. AIM will review each genetic testing request against Anthem's medical policy criteria and if genetic counseling is required under the clinical criteria for that genetic test, AIM will work with the ordering provider to ensure the member obtains genetic counseling prior to completing the prior-authorization.

Q: Where can I find Anthem's genetic testing medical policies?
A: Anthem genetic testing medical policies can be found online at www.anthem.com>Menu>Provider (select state)> Medical Policy

Q. Which members are included in this Genetic Testing program?
A. The program applies to Anthem fully insured members for dates of service on or after 7/1/17. The program will expand to include local ASO and National Accounts that buy up to the Anthem Genetic Testing program administered by AIM for dates of service on or after 1/1/2018.

Q. Which members are NOT included in this Genetic Testing program?
A. It does not apply to members that have benefit plan coverage under the following: Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc, BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, Federal Employee Program® (FEP®), California HMO plans, Hospital Only plans, and Anthem as secondary payor.

Q: If members have a previously approved genetic testing authorization on file, is the ordering provider required to obtain a new authorization from AIM?
A: Anthem will honor previously approved authorizations until the current authorization expires.

Q: Will this program change the member's out-of-pocket cost?
A: This program is not a change to existing benefits at this time. A member's out of pocket cost may be reduced by using in-network labs for genetic testing services. Please refer to the member's plan benefits.

Q: What if the member or physician wants to appeal the Genetic Testing denial?
A: The same appeal processes would apply to the genetic testing medical necessity denial by AIM as other clinical denials. If the genetic test is not clinically appropriate, the request will not be approved.

Q: If the physician orders the genetic test and does not obtain pre-service review through AIM (i.e., prior authorization or precertification), will the service be reviewed post-service?
A: Yes, if the member's benefit plan supports post-service review, the genetic test will be subject to the same medical necessity review post-service. Post-service clinical reviews will be handled by Anthem and an approval or denial for services will be rendered.

Q. Where can I find more information about AIM Genetic Testing?
A. You can find additional program information at http://www.aimprovider.com/genetictesting/

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin:

[View email in a browser]

Network eUPDATE

August 1, 2017
Ohio

Notice of changes to Prior Authorization requirements

The latest edition of *Network Update* from Anthem Blue Cross and Blue Shield has been posted at anthem.com. It includes notification of changes to Prior Authorization requirements. To view the information, go to anthem.com>Tools for providers. Select Ohio, then Network Update.

Note: All prior authorization are available online. The complete list of our Medical Policies and Clinical UM Guidelines may be viewed by going to anthem.com>Tools for providers. Select Ohio, then Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements. And for more information on pharmacy copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit www.anthem.com/pharmacyinformation.

Please don't reply to this email. We want to help you, but replies to these messages aren't monitored. If you have questions, please contact your account or service representative.

VIEW WITH IMAGES | ADD US TO YOUR SAFE SENDERS LIST OR ADDRESS BOOK.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain

CareSource Dual Eligible Special Needs Plan (D-SNP)

Included in this Newsletter is a letter dated September 15th from CareSource (Please see attached documents). Most Member offices have probably received this letter. The letter notes that they want to develop a network to offer a Dual eligible product covering individuals who qualify for Medicare coverage and Medicaid coverage effective January 1, 2019. CareSource has in conversations within the past week indicated that they are willing to contract with Cornerstone to messenger this product to our Members later this year. This note is to clarify that Cornerstone Members can either register per the letter that they want to enroll as a provider directly with CareSource or elect to participate via Cornerstone when the product is messengered later this year. Should you have any questions please contact Harold Bischoff at 419-996-5317 or by email: **hlbischoff@mercy.com.**

P.O. Box 8738, Dayton, OH 45401-8738 | 800 488 0134 | CareSource.com

September 15, 2017

Dear Health Partner:

Thank you for the difference you've made!

CareSource would like to thank you for the lives you have changed! We are grateful to partner with you to improve the health of the communities we serve together.

We are pleased to announce that effective January 1, 2019, CareSource will introduce a Dual Eligible Special Needs Plan (D-SNP) to provide healthcare to the folks in Ohio who need it most.

We understand this type of plan may be new to you. We have enclosed a Frequently Asked Questions reference guide to address questions you may have about the plan and the on-boarding process.

We hope you will join us on our journey to better health outcomes with this special population.

Joining is easy. To initiate the on-boarding process:

- Visit the Join Our Network webpage on CareSource.com
- Complete the New Health Partner Contract Form

For expedited processing, add the unique code "120DSNP" in the contract code field.

For a more detailed overview of the process and what comes next, please refer to the Frequently Asked Questions reference guide.

To ensure you are included in the D-SNP network, you will need to have the New Health Partner Contract Form completed by **October 6, 2017.**

If you have any questions along the way, we are happy to help. Call us at 1-800-488-0134.

Sincerely,

CareSource Health Partner Contracting

Enclosures

CS-P-0277

NAVIGATING CHANGE

CareSource understands the healthcare industry is constantly evolving. We recognize a true partnership can only exist when we listen to and understand our health partners' needs We've designed this Frequently Asked Questions (FAQ) guide to answer some common questions you may have about our onboarding process and the Dual Special Needs Program (D-SNP).

CareSource is ready to make a difference. We hope you are too!

Ready to Join? Let's Get Started!

How Does My Practice Participate?

Electing to participate in the CareSource Dual Special Needs Program (D-SNP) is fast and easy. You can submit your request to add the D-SNP product online by completing the online **New Health Partner Contract Form.** Visit the Join Our Network page on CareSource.com.

Submission of the application is not a guarantee of contract. CareSource, subject to applicable law, retains the sole authority and discretion when deciding whether to enter into a contractual relationship.

You will be asked to provide the following:

- General information such as your tax ID, NPI number, and demographic information
- Providers associated with your practice whom will be added to the contract addendum
- Submission details and necessary attachments

You will need:

- W-9 tax form
- CAQH ID number (if applicable)
- Tax ID number
- NPI number

Important Steps to Remember!

A User's Guide for Completing the New Health Partner Contract Form is provided on the CareSource.com Join Our Network webpage to lead you through the process. Please remember to:

1. Choose the "OH - D-SNP" product from the drop down "Please Add Products" menu.
2. Add the unique code "**120DSNP**" in the Contract Code box as illustrated below for expedited processing.

The CareSource care management team will coordinate the
various services our dual members require. Most importantly, we will notify you if the members have not sought important services such as annual exams and diagnostic testing.

What are the advantages to members who participate in this plan?

CareSource will coordinate Medicare and Medicaid services, assist to members find help in the community, and offer enhanced benefits. D-SNP members can continue to access their Medicare Advantage benefits while their Medicaid benefits cover some of their out-of-pocket costs and provide services not covered by traditional Medicare.

Will CareSource D-SNP members be required to enroll in a CareSource Medicaid plan?

No, CareSource D-SNP members are not required to enroll in the CareSource Medicaid plan.

Will CareSource transition its current Medicare Advantage members to the D-SNP plan once it's effective in 2019?

No. While dual-eligible Medicare Advantage CareSource members may choose to enroll in the CareSource D-SNP plan, there will be no auto-enrollment or requirement for them to do so.

Credentialing Provider List
Through August 3, 2017

Provider	***Specialty***	***Initial Credentialing Date***
Oluwaseun Ajibade, MD	Internal Medicine	April 13, 2017
Meredith Warnecke, CNP William Scherger, MD (Collaborative Physician)	Certified Nurse Practitioner	April 7, 2017
Thomas Zegarski, MD	Family Medicine	April 28, 2017
David Moh, MD	Internal Medicine	May 9, 2017
Carlos De Carvalho, MD	Neurology	May 12, 2017
Cheri Diller, MD	General Practice	May 15, 2017
Zachary Klausing, DC	Chiropractor	June 1, 2017
Scott Cohen, MD	Urology	June 1, 2017
Toye Williams, MD	Internal Medicine	June 1, 2017
Qianli Zhuang, MD	Internal Medicine	June 1, 2017
Vibhav Bansal, MD	Psychiatry & Neurology	June 19, 2017
Scott Wendroth, MD	Pathology	July 1, 2017
Melanie Jungblut, MD	Pediatrics	July 6, 2017
Sara Hess, FNP James Luedeke, MD (Collaborative Physician)	Family Nurse Practitioner	July 7, 2017
Kishore Nallu, MD	Internal Medicine	July 18, 2017
Barry Haines, CRNA	Certified Nurse Anesthetist	July 18, 2017
Ivan Ongom, MD	Internal Medicine	August 3, 2017
Lauren Stoffel, DO	Family Medicine	August 3, 2017
Sandeep Patel, MD	Cardiology	August 3, 2017
Traytan Mains, DO	Rheumatalogy	August 3, 2017
Jennifer Whitehead, MD	Pediatrics	August 3, 2017
Alissa Perry, MD	OB/GYN	August 3, 2017

Cornerstone Staff

Harold Bischoff, FACHE—Executive Director
419.996.5317 or hlbischoff@mercy.com

Cheryl Snider—Credentialing Auditor
419.996.5386 or csnider@mercy.com

Anita Dumm—Credentialing Team Leader
419.996.5389 or ajdumm@mercy.com

Melita Bellman—Credentialing Coordinator
419.996.5314 or MRBellman0@mercy.com

Mechele Fischer, BBA—Financial Analyst
419.996.5330 or mlfischer@mercy.com

Jenifer Stegaman, BHSC—Provider Relations & Education Specialist
419.996.5377 or jstegaman@mercy.com

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