Reminder: Medicare rates are going up July 1, 2015

Under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, Medicare Physician Fee Schedule rates will go up 0.5 percent each year through 2019 starting July 1, 2015.

President Obama signed MACRA of 2015 into law on April 16, 2015. The law extends the current 2015 fee schedule rates, in effect since January 1, 2015 through June 30, 2015. It also permanently eliminates the Sustainable Growth Rate formula. This prevents a 21 percent payment cut to the Medicare Physician Fee Schedule that was scheduled to take effect on April 1, 2015.

2015 Centers for Medicare & Medicaid Services (CMS) compliance requirements

Through your Coventry provider contract, you must meet CMS compliance requirements for First Tier, Downstream and Related Entities (FDRs) each year. These requirements include:

- General compliance and fraud, waste and abuse (FWA) training
- Code of conduct/compliance policies dissemination
- Exclusion list screenings
- Reporting mechanisms for potential FWA and compliance issues
- Offshore protected health information operation reporting
- Downstream entity oversight

Complete your 2015 Medicare attestation

Once you meet the program requirements, your authorized representative must submit the attestation online to avoid changes in participation status. You can submit your attestation within the Aetna Provider Education Portal by following these steps:

2. Type “attestation” in the search field and click “Go.”
3. Select the “2015 Aetna Medicare Compliance Attestation” and log in.

You only need to complete one attestation for both Aetna and Coventry. Failure to meet the FDR compliance requirements annually may affect your participation status.

We’re here to help

For more details on the FDR program compliance requirements, visit www.aetnaeducation.com. Then search “attestation.” Or, you can call our Provider Service Center at 1-800-624-0756.
We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. In developing our policies, we may consult with external professional organizations, medical societies and the independent Physician Advisory Board, which provides advice to us on important issues to physicians. The chart below outlines coding and policy changes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Effective date</th>
<th>What's changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory panels</td>
<td>October 15, 2015</td>
<td>For payment purposes, we'll bundle individual lab codes into the more comprehensive panel code when a designated number of component codes are billed. For more information, refer to the Laboratory Panels section on <a href="#">our secure website</a>.</td>
</tr>
<tr>
<td>Unit maximum on 88271</td>
<td>October 15, 2015</td>
<td>Molecular cytogenetics; DNA probe, each (88271) will have a limit of 20 units per date of service per provider for facility or non-facility. Modifier 91 won't override.</td>
</tr>
<tr>
<td>Anesthetic agent – nerve block</td>
<td>October 15, 2015</td>
<td>Nerve blocks (CPT codes 64400-64530) will be considered incidental to anesthesia codes and ineligible for reimbursement. When billed with modifier 59, post-operative pain blocks for pain management will be allowed when the performed block(s) don’t represent the primary mode of anesthesia. Nerve blocks billed by surgeons don’t warrant separate payment, since the anesthesia provision is included in the surgical procedure.</td>
</tr>
<tr>
<td>Radiation therapy</td>
<td>October 15, 2015</td>
<td>Evaluation and Management codes (E&amp;Ms) will be denied (except the initial consultation) with all radiation therapy procedures and for 90 days after conclusion of the course of therapy. A course of radiation therapy treatment is defined as 8 weeks. Office visit E&amp;Ms will be allowed separately when billed with the following radiation therapy procedures: • 77427 Radiation treatment management • 77431 Radiation therapy management • 77432 Stereotactic radiation treatment management of cerebral lesion We'll limit the payment and frequency of certain radiotherapy procedures that would be expected to occur on the same day or during the course of therapy. For more information on the radiation therapy procedures and frequencies, refer to Radiation Therapy services on <a href="#">our secure website</a>.</td>
</tr>
<tr>
<td>Genetic testing</td>
<td>October 15, 2015</td>
<td>We consider clinically unrelated genetic testing performed with BRCA testing as experimental and investigational. For more information, refer to Clinical Policy Bulletin #0227- BRCA Testing, Prophylactic Mastectomy, and Prophylactic Oophorectomy.</td>
</tr>
</tbody>
</table>
# Policy and coding updates

## Clinical payment, coding and policy changes

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Therapy – evaluations and re-evaluations</td>
<td>October 15, 2015</td>
<td>This is an update to the information provided in the April 2015 newsletter: Therapy evaluations are subject to the following billable timeframes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical therapy (PT) and occupational therapy (OT) evaluations (97001 and 97003), as well as speech therapy evaluations (92521, 92522, 92523 and 92524), are eligible for payment once every 180 days.</td>
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<tr>
<td></td>
<td></td>
<td>• In addition, athletic training evaluations (97005) are eligible for payment once every 180 days.</td>
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<td></td>
<td></td>
<td>Therapy re-evaluations are subject to the following billable timeframes:</td>
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<tr>
<td></td>
<td></td>
<td>• Physical and occupational therapy re-evaluations (97002 and 97004) are eligible for payment once every 30 days.</td>
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<tr>
<td></td>
<td></td>
<td>• Speech therapy re-evaluations (S9152) are eligible for payment once every 90 days.</td>
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<tr>
<td></td>
<td></td>
<td>• Athletic training re-evaluations (97006) are eligible for payment once every 30 days.</td>
</tr>
<tr>
<td>Speech therapy</td>
<td>October 15, 2015</td>
<td>We’ll allow one service per date for code S9128 and four services per date for codes G0153 and G0161, based on diagnoses.</td>
</tr>
</tbody>
</table>
Preauthorization

Changes to our preauthorization lists

Beginning July 1, 2015, precertification is required for gender reassignment surgery if the member’s plan covers the procedure.

Update
- Granulocyte-colony stimulating factor (GCSF) drugs/medical injectables won’t require precertification until January 1, 2016. We originally communicated that GCSF would require precertification on July 1, 2015.

Reminders
Precertification is required for the following services on the effective date noted:
- New-to-market drugs NovoEight (turoctocog alfa) effective April 1, 2015; and Natpara (parathyroid hormone) effective May 1, 2015.
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids is required effective May 15, 2015.
- Xofigo (radium (Ra)-223 dichloride) effective October 1, 2015.

Precertification isn’t required for the following services on the effective date noted:
- Maternity management home care and home uterine activity monitoring effective May 1, 2015.
- Somatuline® Depot (lanreotide) effective May 1, 2015.

Coventry Health Care of Georgia, Inc.
Observation stays longer than 24 hours will require precertification effective October 1, 2015.

For more information, go to the “Providers” section of your plan’s website and look under “Pre-Authorizations.”
Consult CPGs and PSGs as you care for patients

We adopt evidence-based Clinical Practice Guidelines (CPG) and Preventive Services Guidelines (PSG) from nationally recognized sources. You’ll find them on our plan websites. Look under “Providers,” then under “Document Library.” If you need a paper copy, contact your provider relations representative.

<table>
<thead>
<tr>
<th>CPG</th>
<th>Adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma</strong></td>
<td></td>
</tr>
<tr>
<td>Guidelines for the diagnosis and management of asthma</td>
<td>June 2014</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnosis, evaluation and treatment of attention deficit hyperactivity disorder in children and adolescents</td>
<td>March 2014</td>
</tr>
<tr>
<td>Helping patients who drink too much</td>
<td>March 2014</td>
</tr>
<tr>
<td>Treatment of patients with major depressive disorder</td>
<td>March 2014</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
</tr>
<tr>
<td>Standards of medical care in diabetes</td>
<td>April 2015</td>
</tr>
<tr>
<td><strong>Heart Disease</strong></td>
<td></td>
</tr>
<tr>
<td>Prevention and risk reduction therapy for patients with coronary and other atherosclerotic vascular disease</td>
<td>June 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PSG</th>
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<tbody>
<tr>
<td>Gestational diabetes mellitus (GDM) in asymptomatic pregnant women after 24 weeks of gestation*</td>
<td>March 2014</td>
</tr>
<tr>
<td>Mammogram screening for women over 40**</td>
<td>March 2014</td>
</tr>
<tr>
<td>Prevention of the initiation of tobacco use among school-aged children and adolescents*</td>
<td>March 2014</td>
</tr>
</tbody>
</table>

*U.S. Preventive Services Task Force  
**National Cancer Institute
Office News

Stay Informed on the web
Visit us online to view a copy of your Provider Manual as well as information on the following:

- How our Quality Management program can help you and your patients. We integrate quality management and metrics into all that we do. You can find details on the program goals and the progress toward those goals online.
- Learn how we work with members enrolled in our chronic disease management programs, and how to enroll a member in a disease management program.
- Learn about our complex case management program and how to refer members.
- Member Rights and Responsibilities.
- What utilization management is and how decisions are made, including our policy against financial compensation.

Once on our website, you can access these materials by following the paths outlined below:

- **Commercial**—Choose “Quick Links” at the top of the page. Select your plan under “Regional Health Plans.” Then select “Providers,” then “Document Library.”
- **Medicare**—Choose “Quick Links” and then select “Coventry Health Care Medicare Website.” Under “Plan Sites” select your plan from the pull-down menu. Then, choose “Providers,” then “Document Library.”
- **Medicaid**—Choose “Quick Links.” Scroll down to “Medicaid” and select your plan. Choose “For Providers,” then “Document Library.”

If you don’t have internet access, call our Provider Service Center for a paper copy of the Provider Manual.

Are you ready for ICD-10?
As you know, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that ICD-10 code sets replace ICD-9 code sets. Along with you, we’re required to make this change on **October 1, 2015**.

**Share feedback through brief survey**
Your feedback and readiness are important to us. Please take this very brief survey by **August 15, 2015** to let us know.

**Steps you can take**
- Keep working with your billing or software vendors and clearinghouses for conversion information and testing plans.
- Determine the impact of the ICD-10 conversion on clinical, financial, billing and coding processes.
- Read a helpful Q&A on [www.directprovider.com](http://www.directprovider.com). Once logged in, search for “ICD-10 FAQ.”
Coventry Health Plans follow Aetna Clinical Policy Bulletins

As a reminder, our Coventry Health Plans now follow Aetna Clinical Policy Bulletins (CPBs). Our delegated utilization management vendors (including Triad Healthcare, Inc.) also use these clinical guidelines to make medical necessity determinations.

Missouri, Illinois

National Imaging Associates to manage outpatient cardiac catheterizations

Beginning August 1, 2015, National Imaging Associates will manage the authorization process for outpatient cardiac catheterizations for members of:

- Coventry Health Care of Missouri
- Coventry Health Care of Illinois

This applies only to fully-insured commercial and Medicare members.

Coventry requires prior authorization for non-emergent, outpatient cardiac catheterizations. This includes CPT codes 93452 through 93461. The health plan will still manage authorizations for inpatient and emergency procedures.

Please be aware that:

- The ordering physician is responsible for getting prior authorization. Go to www.RadMD.com. Or, call 1-800-642-7835 for Illinois members and 1-800-642-7339 for Missouri members.
- The facility must ensure that the physician received prior authorization.
- We may deny payment to the physician and facility for procedures done without prior authorization. Members can’t be balance-billed for these procedures.

If you have questions call:

- 1-800-755-5242 for Coventry Healthcare of Missouri members
- 1-800-562-5792 for Coventry Healthcare of Illinois members

Missouri

Wellness incentive program available for some Missouri government employees

Coventry Health Care of Missouri is offering a wellness incentive program for members of the:

- Missouri Department of Transportation (MODOT)
- Missouri State Highway Patrol (MSHP)

The program encourages preventive visits and screenings by offering MODOT and MSHP members a chance to be entered in a drawing to win a $50 or $100 gift card. To be eligible, members need to have at least one preventive care office visit or service in 2015. Retirees, spouses, and dependents aren’t eligible. There are no out-of-pocket charges to members for preventive care when they see in-network providers.

If you have questions, e-mail Robin Gammon at rlgammon@cvty.com or call 1-314-506-1632.

Missouri

Use the Carpenters™ H&W Trust Fund of St. Louis provider portal for these functions

Carpenters H&W Trust Fund of St. Louis has its own provider portal. You can use this portal to:

- Verify member eligibility and benefits
- View the status of claims
- Sign up for Electronic Fund Transfers (EFT) and Electronic Remittance Advice (ERA)

To use the portal, go to https://slc.webspyglass.com and select “provider logon screen.” You’ll need your NPI, billing provider tax ID and billing provider zip code to access your records.