April 2018
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

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All Providers

How and When to Check Eligibility

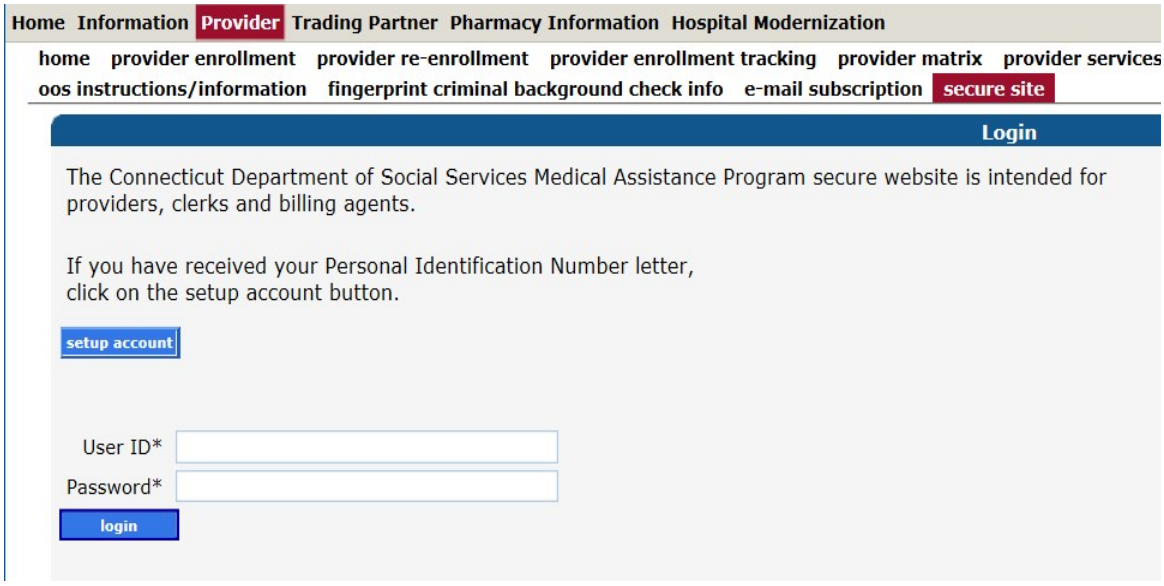
Because eligibility can change at any time, providers are encouraged to check a client's eligibility at the time of referral, start of care, return to care after an absence and at frequent intervals. Eligibility can be checked using the following methods:

Secure Web portal account at www.ctdssmap.com
Automated Voice Response System (AVRS)
Provider Electronic Solutions (PES) software
Point of Sale (POS) Device
ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction
e-Prescribing using SureScripts and the ASC X12N 270/271 transaction

This article only provides instruction on verifying eligibility via the Secure Web portal. For more information regarding the three additional eligibility verification methods, please refer to chapter 4 of the Provider Manual.

To check a client's eligibility on the Secure Web portal follow the steps below.

1. Log into the www.ctdssmap.com secure Web portal.



2. Click on the *Eligibility* tab on the main menu.

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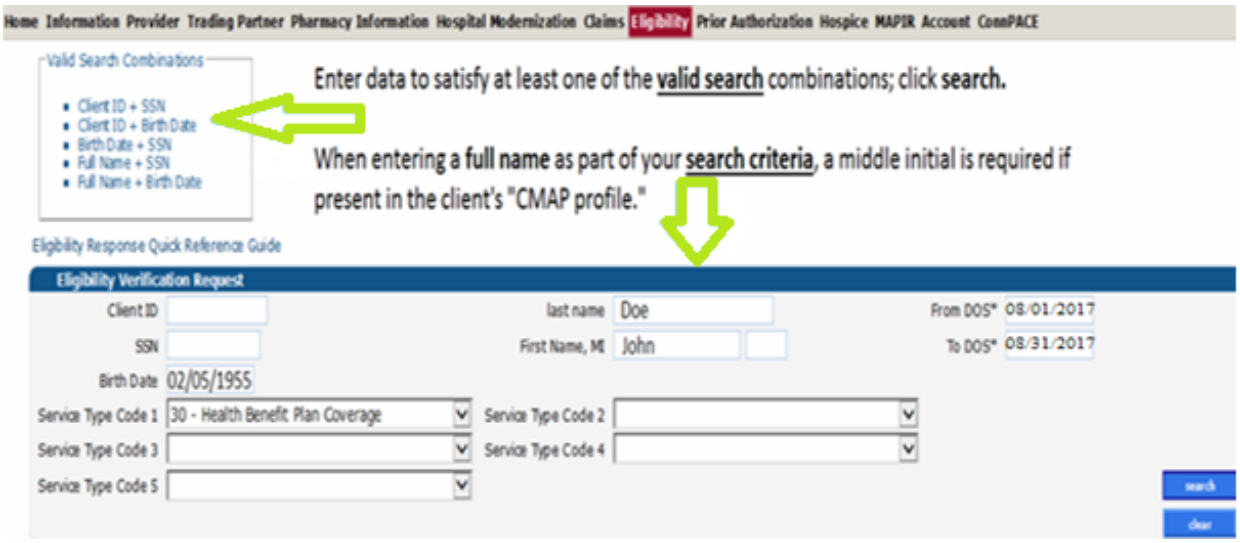
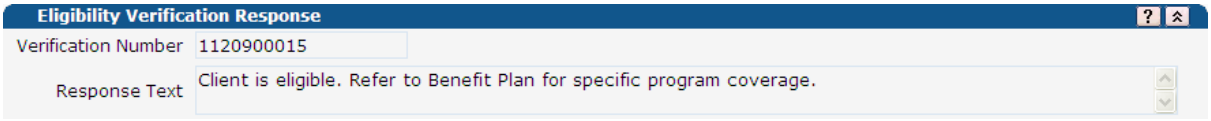
(continued from page 1)

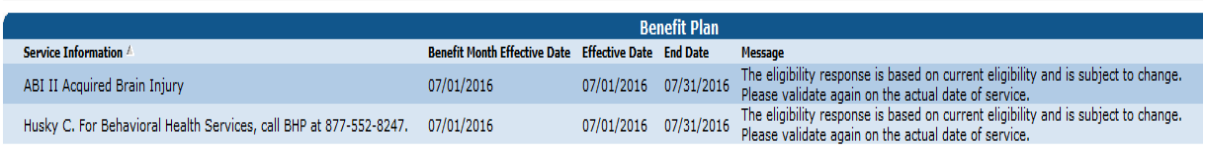
3. Enter enough data to satisfy at least one of the *viral search combinations;* click *search.*



4. When your results are returned, you will be able to determine if your client is currently eligible for services. You will want to record the Eligibility Verification number in case the client's coverage is retroactively changed at a later date. The Eligibility Verification number proves you researched the client's eligibility and verified coverage at the time of service.



5. The Benefit Plan section will tell you if the Client is active on Medicaid and/or waiver benefit plan on the date(s) of service requested.



Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
ABI II Acquired Brain Injury	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.

6. The Medicare tab will tell you if the client has Medicare in their list of payers. The TPL tab will tell you if the client has a third party payer. If the client has payers in these tabs, they will need to be billed for payment or denial prior to submitting a claim to Medicaid.

If you require additional assistance in researching and understanding eligibility, please contact the Provider Assistance Center at 1-800-842-8440.

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When Is It Appropriate to Use Procedure Codes T1001 and G0162 for Waiver Clients?

An Important Message titled "Additional Guidance on the Use of the Home Health SOC/ROC and Recertification Service Codes for CHC, ABI, PCA and Autism Waiver Clients" was recently published providing guidance for Home Health providers in the use of the T1001 and G0162 service codes. This article will further assist providers in their use of these service codes as related to waiver clients.

The 60-day recertification code (G0162–Skilled Services by a Registered Nurse (RN) for management and evaluation of the care plan) is to be used to bill for the review of a client's care plan. The recertification of care plans for skilled nursing services must be completed within the 60-day window after the completion of the start of care (SOC)/resumption of care (ROC). Every recertification visit thereafter must be completed within the 60-day window after the completion of the previous recertification.

DSS has recommended that access agencies create an *annual* Prior Authorization (PA) for a minimum of twelve (12) units for the recertification visits, (two (2) units per each 60-day recertification visit representing six (6) 30 - minute evaluation visits per year), for clients with the CT Home Care (CHC), Acquired Brain Injury (ABI), Personal Care Assistance (PCA) and Autism waivers. This annual PA will ensure that a PA for the service being provided is present on the Web portal prior to a visit being conducted and is available for scheduling in the EVV Santrax® system for CHC, ABI and PCA waiver clients.

If the visit duration extends beyond the initial authorized units of two (2) units per visit, the provider must contact the access agency overseeing the client's care for additional units. The provider can request up to an additional four (4) units, to reach the maximum of the six (6) units allowed per visit. Units requested in excess of the maximum of six (6) units allowed per visit will require further authorization from DSS.

If a client is active on their appropriate waiver benefit plan, is hospitalized and returns to the same home health agency for services under their waiver benefit, the initial visit after the hospitalization should be billed as a Resumption of Care (ROC) using service code T1001 – Nursing assessment/evaluation. A 60-day recertification (procedure code G0162) should be performed within 60 days from the ROC.

If a client has Medicare coverage as the primary payer, is hospitalized and returns to home health services under **Medicare** coverage, per Medicare guidelines an oasis evaluation is required to return the client to Home Health services. Medicare would be billed for the initial oasis evaluation, ordered services and further 60-day oasis evaluations. When the client no longer meets the Medicare level of care, nursing services should be billed to Medicaid via the clients appropriate waiver benefit plan and a G0162 should be performed no more than 60 days from the last recertification.

If a client no longer meets Medicare's level of care for home health benefits, is hospitalized and returns to home health services under Medicaid coverage via their waiver benefit plan, a Resumption of Care, service code T1001, should be performed and billed to Medicaid. A 60-day evaluation from the day the client returned to service with Medicaid level of care and every sixty days thereafter should be performed and billed under the 60-day recertification procedure code, G0162.

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Attention All Providers

Proper Use of Review through Written Correspondence

With the elimination of paper claims, electronic claim submission has really expedited the processing of claims. However, some providers may be asking, "What should I do if I have two duplicate claim denials for a client's ambulance trips on the same day for the same client?" or "What happens when a client has been retroactively deactivated, but was active when eligibility was verified, resulting in a claim denial related to eligibility?". This article has been created to assist providers with proper use of written correspondence.

This process begins with a claim denial or an issue that a provider will need to escalate to our Provider Assistance Center (PAC), at 1-800-842-8440. When speaking with your PAC representative, make sure to have all of your information in front of you, and be able to explain your claim issue clearly. If your claim is deemed necessary to go to written correspondence, your PAC representative will be able to instruct you on submission procedures.

What is needed for the submission to written correspondence? Each situation may be slightly different, but in order to submit your claim to written correspondence you will need:

1. The specific claim you need reviewed. (The claim must be submitted on an original red and white claim form.)
2. A written explanation as to why this claim is in need of review, on your institution's letterhead with a signature.

Any and all documentation pertaining to the claim, supporting the need for the circumstances submitted in the claim.

What are some situations where submitting to the Written Correspondence Unit is necessary? Here are some reasons a provider might have to write to Written Correspondence.

- Medicare Denied as Duplicate Claims (where first detail line of Medicare coinsurance/deductible claim pays and remainder deny as duplicate)
- Inpatient claims for clients who are retroactively eligible for HUSKY C or D to a date between the admit date and the discharge date, but not retroactively eligible on date of admission
- Provider Request to override hysterectomy or sterilization consent form when no consent form has been obtained due to extenuating circumstances.
- Request to Add Procedure Code. Provider would need supporting documentation to justify the request
- Request to Review Facility Type Restriction, Diagnosis Code Restriction, Gender Restrictions
- Request to Override Explanation of Benefit (EOB) code 5261 (surgical procedure & established patient not covered same date of service [DOS]), 5262 (Surgical procedure includes follow up hospital care), or 5265 (hospital not covered following surgery)
- Duplicate claim denials due to two or more ambulance trips for the same client, date of service, and origin/destination modifier
- Provider requesting payout for client not eligible when verification number received stated client was eligible
- Provider requesting assistance with timely filing

For all written correspondences, providers should include all the proper documentation, and mail it to the following address: Written Correspondence, P.O. BOX 2991, Hartford CT, 06104. When checking on the status of your claim while logged into the secure Web site, you will be looking for an ICN (Internal Control Number) that begins with either an 11, 12, or 13 indicating it is a special handled claim on paper.

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Attention Hospice Providers

Important Reminders for Hospice Providers

The Department of Social Services and DXC Technology would like to provide Hospice providers with a few reminders that will help streamline your daily processes and promote successful claim submission and ultimately reimbursement for the services rendered to HUSKY clients. Below are reminders with instructions that will guide you towards success!

First (1st) Reminder:

All hospice transactions must be submitted in a timely manner. Corrections to hospice transactions that were originally submitted can be made up until the transaction appears on the client's eligibility file, which may take up to fourteen business days from the date the transaction was submitted. Corrections submitted once the eligibility file has been updated will not be allowed. Occurrences that prevent providers from entering timely transactions can be found in provider bulletin PB14-80. Providers that are prohibited from filing transactions within the time requirements because of one of the qualifying circumstances listed in provider bulletin PB14-80 must contact the Provider Assistance Center (PAC) at 1-800-842-8440 for review and/or escalation assistance.

Second (2nd) Reminder:

Providers are also reminded of the **steps to follow when a client is retroactively granted eligibility with either HUSKY A, HUSKY B, HUSKY C or HUSKY D.** Important: Providers **only** have **seven (7) business days** from the date the client appeared on the eligibility file to enter in time restricted transactions, such as election hospice services, transfers and extensions. Though discharges can be submitted at any time, providers must also enter them in a timely manner to avoid delay in entering additional transactions or delaying treatment by other providers caring for the client.

Consequently, providers are encouraged to implement a quality assurance process to ensure all daily transactions have been submitted timely and processed as expected and that providers do not miss the seven (7) business day timeframe from the date the client's eligibility was inserted when a client is retroactively granted eligibility. It is the provider's responsibility to maintain the lock-in as applicable to the client's treatment and request as defined in the Hospice Regulations. Failure to do so could interrupt your internal cash flow as well as impact other providers.

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Physicians, APRNs, PAs, Independent Radiology Providers and Hospitals

Prior Authorization Reminder for Advanced Imaging Services

Connecticut Medical Assistance Program (CMAP) providers are reminded that, when certain services are performed in an outpatient hospital setting, the provider MUST request authorization using the corresponding Healthcare Common Procedure Coding System (HCPCS) "C" code instead of the Current Procedural Terminology (CPT) code. For a list of corresponding codes, the providers can refer to provider bulletin 2017-27 "Reminder About Use of "C" Codes for Certain Advanced Imaging Services." Hospitals can also refer to the Prior Authorization Grid for Outpatient Hospitals on the Hospital Modernization Page on the www.ctdssmap.com Web Site. Hospitals must confirm that a valid, approved authorization is on file for the appropriate "C" code prior to performing the service. If the authorization on file does not have a "C" code, the outpatient claim will deny and the hospital would need to contact Community Health Network of CT (CHNCT) at 1-800-440-5071 for assistance.

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Reminder to Providers on the Re-enrollment Process

The Department of Social Services (DSS) requires most providers to re-enroll online. The majority of provider types are required to re-enroll every five (5) years. Certain provider types are required to re-enroll every two (2) years. For those unsure of your particular re-enrollment period you can access the Provider Matrix by going to the ctdssmap.com website, click on Provider > Provider Matrix > and click the link for "Follow on Document Requirement by Provider Type and Specialty".

The majority of our providers who re-enroll online will receive a reminder letter when they are due for re-enrollment six (6) months prior to the end of their re-enrollment due date; nursing home providers will receive a reminder letter when they are due to re-enroll eight (8) months prior to their re-enrollment due date. Online re-enrollment cannot be initialized until an Application Tracking Number (ATN) is received from the DXC Technology Provider Enrollment Unit. Once this letter has been received, you can go to www.ctdssmap.com to begin the process. Simply click on Provider, then Provider Re-Enrollment. While the majority of the required information is automatically populated based on the information currently stored for the provider, it is important to remember that, prior to starting your re-enrollment, you should have all necessary information gathered as there is no “save for later” functionality. Reminder: if you have additional required documentation to be sent to the DXC Technology Provider Enrollment Unit, we ask that you please write your ATN on top of the document so it can easily be associated with your re-enrollment application.

Once you have submitted your re-enrollment, you will be able to check the status of your application online. Go to www.ctdssmap.com, click on Provider, then Provider Enrollment Tracking. On the next screen you will be asked to input the ATN number and Business OR Last Name, then click Search. From here you, will be able to see the most current status of your application. You can refer to Chapter 10 to see a list of possible application statuses and their descriptions. DXC Technology recommends providers begin this process well in advance of the re-enrollment date to avoid disenrollment due to untimely submission which will result in claim denials.

For greater detail on the re-enrollment process please refer to Chapter 3 and Chapter 10 of the Provider Manual. Both chapters can be found on the ctdssmap.com Web site in Information > Publications under the Provider Manuals heading. For information on specific enrollment periods by provider type, required follow on documentation (if applicable), license requirements and a list detailing those providers who cannot bill via the web portal, go to the ctdssmap.com website, click on Provider > Provider Matrix > and click the link for "Follow on Document Requirement by Provider Type and Specialty”.

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Attention Hospice Providers

All Patient Refined-Diagnostic Related Group (APR DRG)

Inpatient hospital payment methodology is processed based on the Diagnostic Related Group (DRG) returned from the APR DRG grouper. To help hospitals determine the DRG code and the allowance on their inpatient claims, 3M Health Information Systems has made a tool available to the hospitals to determine the APR DRG code based on input of several data elements on the inpatient claim. The tool is available on the Web site www.aprdrgassign.com. In order to access this Web Site, users will be required to enter a User ID and Password. To obtain this User ID and Password, please send a request via e-mail to **ctxixhosppay@dxc.com**.

Once the hospital has verified the DRG code from the www.aprdrgassign.com Web site, the hospitals can use the interactive DRG calculator to determine the DRG payment amount. The interactive DRG calculator is available on the "Hospital Modernization" page on the www.ctdssmap.com Web site. Instructions to use the 3M tool or the interactive DRG calculator are available from the "Hospital Modernization" page. Under "Helpful Information" on this page, click on "Provider Training", and then under "Materials", click on "Hospital Workshops".

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Attention All Providers

Important Messages on the Web

Please be sure to reference Important Messages found on our Web Site www.ctdssmap.com, located on the Home Page and under the Information tab. These messages contain important information on the Connecticut Medical Assistance Program including areas such as Hospital, Dental, Electronic Visit Verification (EVV), Home Health, Hospice, Autism Waivers, Physicians, Pharmacy and Transportation. The messages are constantly updated and posted with the most current information available. If you signed up for an email subscription, you will receive copies of Important Messages that are geared to your specialty. If you do not currently receive emails on the messages posted and would like to receive them, you can register for Email Subscription from the Home Page. Type in and then confirm your E-mail, select the Subscriptions you would like to receive and Register. This is a valuable tool that contains a wealth of information.

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Attention All Providers

Cologuard Notification to Providers

The Department of Social Services would like to remind all providers about the coverage guidance for the Cologuard test (CPT 81528), a test created and owned by Exact Sciences. Please be aware, Exact Sciences is not an enrolled Medicaid provider, therefore, the Cologuard test is not a covered benefit under Connecticut Medicaid. It is the responsibility of all enrolled providers to make members aware of offered services that are not be covered by Medicaid. Alternatively, providers may refer to the current 2018 Connecticut Medicaid Consolidate Laboratory fee schedule, for comparable blood tests.

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Attention Dental Providers

Annual Dental Benefit Maximum

Dental providers enrolled in the Connecticut Medical Assistance Program (CMAP) were notified via Provider Bulletin 2017-81 about the implementation of the annual dental benefit maximum of $1,000 for dental services provided to adult clients ages 21 and older enrolled in HUSKY A, C and D benefit plans effective for dates of service January 1, 2018 and forward. The dental benefit limit resets on January 1st of each year.

Claims History for Specific Services functionality: Before providing the service(s), the provider should verify the total of each client's accrual of services towards the annual dental benefit limit from their secure provider portal on **www.ctdssmap.com** by selecting "Claims" > "Claim History for Specific Services" and selecting the "Inquiry Type" of "Dental Benefit Limit".

Explanation of Benefit (EOB) Code 6250 – Dental Annual Benefit Limit Exceeded and Client Responsibility: Once the Dental Benefit Limit has been reached and a claim is submitted for the client, the detail(s) will post "EOB code 6250 – Dental Annual Benefit Limit Exceeded." For any detail that posts EOB 6250, the Remittance Advice (RA) will list the amount for which the client is responsible; unless services are prior authorized for medical necessity.

Dental providers who submit a claim for a client nearing his or her annual benefit maximum limit will receive a partial payment up to the annual maximum of $1000. Once the client reaches the annual benefit maximum, the entire billed amount of any further detail(s) will be the client's responsibility.

The client may not be billed unless and until they have signed a form indicating that the proposed service is not covered because it exceeds the maximum, but they are willing to assume responsibility for payment. Such consent shall include a specific financial statement describing the service(s) for which he or she accepts responsibility. A client may also consent to partial payment for a service or procedure, if the remaining accrual amount will cover only part of the cost of the service. Again, this consent must be obtained *before* the procedure(s) is performed.

Medically Necessary Services: If the dental services are medically necessary even though the client has reached the annual dental benefit limit, the provider should request prior authorization (PA) for the service (s) through the Connecticut Dental Health Partnership (CTDHP) through hard copy or by logging into their provider portal under "Provider Partners" on www.ctdhp.com. The full remaining treatment plan should be submitted including all supporting documentation required to substantiate reasons of medical necessity, including but not limited to radiographs, photographs, written commentary and statements of medical necessity from the client's primary care provider.

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Holiday Schedule

Date	Holiday	DXC Technology	CT Department of Social Services
5/28/2018	Memorial Day	Closed	Closed
7/4/2018	Independence Day	Closed	Closed
9/3/2018	Labor Day	Closed	Closed
10/8/2018	Columbus Day	Open	Closed

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Appendix

Provider Bulletins

Below is a listing of Provider Bulletins that have recently been posted to www.ctdssmap.com. To see the complete messages, please visit the Web site. All Provider Bulletins can be found by going to the Information -> Publications tab.

PB18-19 Web Portal Enhancement—Alternate Service Location Addresses

PB18-18 Corrected and Revised—Reductions and Adjustments to Payment for Durable Medical Equipment (DME) to Remain Compliant with Federal Law and Additional Reimbursement Reductions to Medical Equipment, Devices And Supplies (MEDS)

PB18-17 Electronic Visit Verification Enhancement—Alternate Claim Solution

PB18-16 Tisagenlecleucel (Kymriah™) and Voretigene Neparvovec-rzyl (Luxturna™) Coverage Guidelines

PB18-15 Reductions and Adjustments to Payment for Durable Medical Equipment (DME) to Remain Compliant with Federal Law and Additional Reimbursement Reductions to Medical Equipment, Devices and Supplies (MEDS)

PB18-14 Changes to Pricing Methodology for Certain Miscellaneous Custom Wheelchair Components Billed under Procedure Code K0108

PB18-13 Payment Error Rate Measurement (PERM) Program Audit Requests

PB18-12 Requesting Authorization for Non-emergency Ambulance Services for Retroactive Eligibility

PB18-11 Timely Completion of Medical Records in the Office and Outpatient Settings

PB18-10 Updates to the Reimbursement Methodology For Physician-Administered Drugs, Immune Globulins, Vaccines and Toxoids

PB18-09 AS Modifier

PB18-08 Updated MEDS Fee Schedule Changes

PB18-07 Autism Waiver Semi-Annual Provider Reports

PB18-06 Billing Clients for Missed Appointments Reissue of PB15-05

PB18-05 Updates to HUSKY Plus Benefit Limits for Medical Equipment, Devices and Supplies And Therapy Services

PB18-04 2018 CMAP Addendum B—Outpatient Hospitals—Annual Update

PB18-04 Coding Changes for Eteplirsen and Nusinersen

PB18-04 Update to Outpatient Hospital Prior Authorization Grid

PB18-03 Peer-to-Peer Review and Reevaluation for Medically Necessary Determinations—Licensure Requirements

PB18-02 Non-Emergency Medical Transportation (NEMT) for Pending Members

PB18-01 Weather Related Transportation Cancellation/Delays

PB17-95 2018 Dental Fee Schedule HIPAA Compliance Update

PB17-94 Prior Authorization for all Non-Emergency Medical Transportation (NEMT)

PB17-93 Announcement of Non-Emergency Medical Transportation (NEMT) Contractor

PB17-92 New Clinical Guidelines—Prior Authorizations (PA) Cranial remodeling Devices

PB17-91 Deletion of Select CPT Codes Listed on the Physician Office and Outpatient Fee Schedule

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What regular feature articles would you like to see in the newsletter? We would like to hear from you!!

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