October 2016
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- All Providers: Paper Claims Elimination Mandate
- Home Care Providers: Electronic Visit Verification Updates and Modernization
- All Providers: Web Claim Adjustment—Timely Filing
- Dental Providers: Do You Know What *Medicare Covered Service Benefit Plan* Means?
- All Providers: Completion of Timely Re-Enrollments
- Outpatient Hospital Providers: Hospital Outpatient Reimbursement Modernization

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Attention: All Providers

Paper Claims Elimination Mandate

Providers were notified via provider bulletin PB 2016-31 that, effective October 1, 2016, the Department of Social Services (DSS) will no longer accept paper claims for processing. DSS is directing this change as a means to provide a more streamlined and cost effective method for reimbursement for the Connecticut Medical Assistance Program. Paper claims submitted to Hewlett Packard Enterprise on or after October 1, 2016 will be returned to the provider. P.O. Boxes 2941 and 2961 will no longer be valid as of this date.

The only two exceptions for accepting paper claims are:

- Out of State providers who currently submit paper claims;
- Any provider claims that are submitted to Hewlett Packard Enterprise for special handling, such as timely filing overrides.

Providers should refer to Chapter 1 of the Provider Manual to obtain current mailing addresses for these paper claim exceptions. This may be accessed on our Web site www.ctdssmap.com under Information > Publications > Provider Manual.

After a careful review of paper claims currently being submitted to Hewlett Packard Enterprise, a trend was noticed whereby a lot of providers who submit Medicaid primary claims electronically resorted to paper claims when it came to submitting Medicare primary or Commercial Insurance primary and Medicaid secondary claims. DSS does not require any Explanation of Benefits (EOB) from primary insurance as an attachment on Medicaid secondary claims, so there is no need to submit these claims on paper. Your vendor software should be able to handle submitting Coordination of Benefits information on the claims and submit secondary claims electronically to us.

Providers should work with their software vendor in order to transition to submit all claims to Hewlett Packard Enterprise electronically, using the ASC X12N 837 Health Care Claim. Alternately, providers can utilize the Web claims submission tool available to providers through their secure Web portal account at www.ctdssmap.com. Please visit our Provider Training page for presentations on Web claims submission for the different claim types.

A very helpful "Other Insurance and Medicare Billing Guide" is available to providers as a reference for billing Medicaid secondary claims. Providers may access Chapter 11 of the Provider Manual from our Web site www.ctdssmap.com under Information > Publications > Provider Manual. Once on that page, select your claim type from the drop down options for Chapter 11 and click on "View Chapter".

Note about Medicare Crossover claims: Medicare primary and Medicaid secondary claims should crossover directly from Medicare to Medicaid after Medicare has made a payment. For crossover claims to process correctly, the claims when received from Medicare must include the billing provider NPI and taxonomy that providers enrolled with in CMAP. Please confirm with your software vendor that the billing provider taxonomy is not being removed from your claims submitted to Medicare. It is imperative that your crossover claims include the billing taxonomy in order for CMAP to correctly process your claims and identify a unique AVRS ID.

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Attention In-Home Care Providers

Electronic Visit Verification (EVV) Updates and Support

Effective for dates of service November 1, 2016 forward, Home and Community Based providers who deliver non-medical services to clients enrolled in the Connecticut Home Care, Personal Care Assistance and Acquired Brain Injury programs will be required to implement the Department's new Electronic Visit Verification (EVV) system for purposes of scheduling, visit verification and claim submission. Home Health agencies providing medical services will be required to implement the Department's EVV system effective for dates of service January 1, 2017 forward.

Instructor-led and Webinar-based trainings have been completed and the training materials are located on the EVV Important Message located on www.ctdssmap.com. These trainings were mandatory for all provider agencies and were a requirement to receive your Welcome Kit, which details how to access your Sandata EVV system. **If your agency did not complete training, you will be required to successfully complete the pre-recorded training videos located on the EVV Important Message in order to receive your Welcome Kit**.

If your agency did complete training and did not receive your Welcome Kit, please contact Sandata customer service at ctcustomercare@sandata.com or by telephone at 1-855-399-8050.

Do you have EVV questions and don't know where to go for help? The list below can get you started in the right direction.

- 3rd Party Interface, Santrax EVV system, Technical Assistance – Contact Sandata at ctcustomercare@sandata.com or by telephone at 1-855-399-8050.

- Claims, Payment and Billing Issues–Contact Hewlett Packard Enterprise at 1-800-842-8440.

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Attention All Providers

Web Claim Adjustments: Timely Filing

The following are Web claim adjustments that <u>can</u> be submitted through the secure Web site www.ctdssmap.com:

- Claims that are not past timely filing.

- Claims that are past timely filing that will pay the same or less than the original claim and the services are not adjusted**.**

For HUSKY C and D clients, timely filing guidelines are one (1) year from the date of the most recent Remittance Advice (RA) for medical, dental, or behavioral health services. For HUSKY A and HUSKY B, timely filing guidelines are one (1) year from the date of the most recent Remittance Advice (RA) for non-behavioral health services and 120 days for behavioral health services.

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For additional timely filing guidelines, providers can refer to Provider Manual Chapter 5 "Claim Submission Information" located on the Publications page of the www.ctdssmap.com Web site.

The following are Web claim adjustments that <u>cannot</u> be submitted through the secure Web site www.ctdssmap.com.

- Claims that are past timely filing that would allow more than the original claim. If the provider tries to adjust these claims, they will be denied for timely filing and the original payment will be recouped.
- Claims that are past timely filing, but the services were modified, even if they pay the same or less.
- Claims that begin with either Internal Control Number (ICN) 12 or 13. These claims were special handled by Hewlett Packard Enterprise and the provider should not adjust these claims prior to contacting Hewlett Packard Enterprise.
- Medicare Crossover Claims. These must be voided, copied and then submitted as new claims.

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Attention Dental Providers

Do you know what *Medicare Covered Service Benefit Plan* means?

Providers participating in the Connecticut Medical Assistance Program (CMAP) are advised to verify client eligibility on the date of service. Providers can easily verify client eligibility by logging into their secure Web portal account from www.ctdssmap.com. The verification response returns information on whether the client is eligible or not; if eligible, the verification response shows the benefit plan in which the client is enrolled. It is important to know that dental services may or may not be covered under the different benefit plans available in CMAP.

Do you know what "*Medicare Covered Service Benefit Plan*" means?

- Benefits are limited to the payment of Medicare *coinsurance* and *deductible* amounts for procedures, assuming the service is a covered benefit under Medicare and the Medicare *paid amount* is less than the Medicaid *allowed amount*. Charges that are denied or are not covered by Medicare are not covered services under this benefit plan.

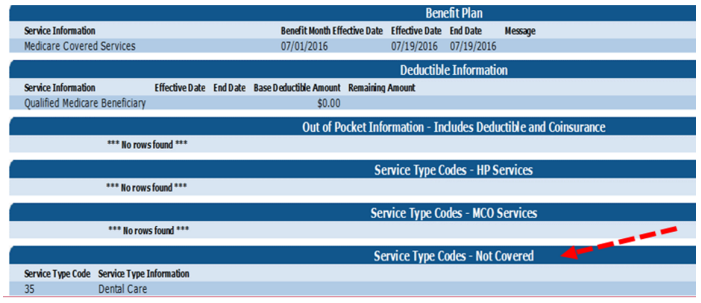
Are dental services covered under this benefit plan?

- Since dental services other than select oral surgical procedures are not covered under Medicare, a client who only has the Medicare Covered Service Benefit Plan does not have dental benefits under CMAP.

How can I see if dental services are covered under Medicare Covered Services Benefit plan?

- Select 35 as the Service Type Code when verifying eligibility. The eligibility verification for a client with Medicare Covered Service Benefit Plan will show Dental Care is not a covered service.

Providers can refer to the Eligibility Response Quick Reference Guide for a complete list of Benefit Plans in CMAP, the program benefits covered under the different plans and where to apply for prior authorizations for the various benefits.



Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
Medicare Covered Services	07/01/2016	07/19/2016	07/19/2016	

Deductible Information

Service Information	Effective Date	End Date	Base Deductible Amount	Remaining Amount
Qualified Medicare Beneficiary			$0.00	

Out of Pocket Information - Includes Deductible and Coinsurance

*** No rows found ***

Service Type Codes - HP Services

*** No rows found ***

Service Type Codes - MCO Services

*** No rows found ***

Service Type Codes - Not Covered

Service Type Code	Service Type Information
35	Dental Care

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All Providers

Timely Completion of Re-Enrollments on the Web Portal

Have you received your notice that it is time to re-enroll? If you answered yes, providers are encouraged to complete their re-enrollment application as quickly as possible upon receipt of their notice to allow ade-quate time for processing and to avoid being dis-enrolled from the Connecticut Medical Assistance Pro-gram (CMAP). Unless notified otherwise, providers are required to re-enroll using the on-line Re-enrollment Wizard.

Non-Nursing Home and Non-ICF/IID providers are mailed a letter six (6) months in advance of their "re-enrollment due date" with instructions to re-enroll. Providers that have not successfully re-enrolled within three (3) months after receiving the initial notice will receive a subsequent letter reiterating the date in which the re-enrollment application must be complet-ed. At this point, it is imperative that providers take action immediately. Providers whose re-enrollment applications are not fully completed by the provider's "re-enrollment due date" will receive a final notice ad-vising them they have been dis-enrolled from the CMAP.

Nursing Homes and ICF/IID providers will receive their notice eight (8) months in advance of their "re-enrollment due date" instead of six (6) months. Nurs-ing Homes and ICF/IID providers that do not re-enroll in a timely manner will be subject to additional outreach, including telephone and correspondence reminders that their re-enrollment is due by the "re-enrollment respond by date" printed on the re-enrollment notice. Providers that have not successfully re-enrolled thirty (30) days before the provider's "re-enrollment respond by date" will receive a notice warning of pending dis-enrollment. Providers whose re-enrollment applica-tions are not fully completed by the provider's "re-enrollment due date" will receive a final notice advising them they have been dis-enrolled from the CMAP.

Complete instructions regarding how to re-enroll are available on the CMAP Web site at www.ctdssmap.com. Providers may refer to Chapter 10, Section 10.7 of the Provider Manual for step-by-step instructions on CMAP Web portal re-enrollment. To access Chapter 10 from the Home page, click on "Publications" then scroll down to Chapter 10, Web Portal/AVRS.

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Outpatient Hospital Providers

Hospital Outpatient Reimbursement Modernization

Effective for dates of service July 1, 2016 and after, the Department of Social Services (DSS) implemented the outpatient reimbursement methodology, using the Outpatient Prospective Payment System (OPPS).

A letter was sent via email to each hospital's chief financial officer (CFO) and all hospital contacts in June 2016 on the specific rates and parameters that will be used for their hospital's reimbursement on outpatient hospital claims. The letters issued describe the Provider Specific Rates for the Medicaid Provider ID and gave the Wage Adjusted Conversion Factor and the Cost-to Charge Ratio for Outliers only. They also listed the Statewide Parameters Conversion Factor, Outlier Multiplier and Outlier Thresholds for each hospital.

These letters can be referenced by going to the www.ctdssmap.com Web site and clicking "Hospital Modernization" page. In the right column, under the third heading "DSS Links", click "DSS Reimbursement Home Page". This will bring you to the DSS Reimbursement Modernization Web site. Next click on "Outpatient Hospital Payment Methodology" and you will be routed to the Hospital Outpatient Reimbursement Modernization page. Under the June 24, 2016 Timeline, you will find a link for Rate letters for Connecticut Hospitals. This is where hospitals can reference the rate letters for their specific hospital. The Wage Adjusted Conversion Factor is the amount calculated in figuring out the Ambulatory Payment Classification (APC) payment on an outpatient hospital claim. Examples of APC payment can be found in the "Hospital Modernization Workshop Presentation 2016" located on the Provider Training page at www.ctdssmap.com under "Hospital Modernization". Hospitals can also view the estimated fiscal impact calculations for each hospital under the Rate letters link.

Questions on APC billing should be submitted via email to ctxixhosppay@hpe.com.

Please visit the "Hospital Modernization" page on the www.ctdssmap.com web site for any current updates.

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Attention: All Providers

Electronic Funds Transfer (EFT) Requirement Reminder

As a reminder, the Department of Social Services (DSS) requires providers to receive payment through Electronic Funds Transfer (EFT) to the provider's financial banking institution. As part of the ongoing initiative to reduce expenses, DSS is moving away from issuing paper checks. As a result, you must take action immediately to enroll in EFT. Failure to enroll in EFT may result in payments from CMAP being withheld until a provider's EFT enrollment has been completed. To enroll in EFT, visit the provider Web site at www.ctdssmap.com and log into your Secure Web portal account. Once logged in, click on the Demographic Maintenance tab. Once enrolled in EFT, providers may change their EFT data at any time. Only the main account holder is permitted to add/update EFT information.

Please refer to the Provider Demographic Maintenance section in Chapter 10 of the Provider Manual for further instructions on how to update this information. Chapter 10 is located on the www.ctdssmap.com Web site by selecting Information > Publications and then scrolling down to Provider Manuals.

Please note, once you add or update EFT information, you will receive a paper check for one financial cycle, so that a test transaction can be sent to your financial institution to validate the account information that was provided. No further action is required in this case. You will receive your payment via EFT in the next financial cycle in which you have claim activity.

If you need assistance in establishing your secure Web portal account, resetting a password or enrolling in EFT, please contact the Provider Assistance Center at 1-800-842-8440.

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Appendix

Holiday Schedule

Date	Holiday	HPE	CT Department of Social Services
10/10/16	Columbus Day	Open	Closed
11/11/16	Veterans' Day	Open	Closed
11/24/16	Thanksgiving Day	Closed	Closed
11/25/16	Day after Thanksgiving	Closed	Open
12/26/16	Day after Christmas	Closed	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.

PB16-60 Annual Reassessment: Provider Attendance and Location

PB16-59 Fingerprint-Based Background Checks For Newly and Re-enrolling "High-Risk" Medicaid Providers

PB16-58 Change to the Early Refill Criteria

PB16-57 Prior Authorization Requirement for Several Orthotic Devices

PB16-56 Electronic Visit Verification Reporting A Change in Client

PB16-55 Reimbursement Update of Code 81528 On Independent Laboratory Fee Schedule-Revised Sept. 9, 2016

PB16-54 Caregiver Time Documentation Best Practices in EVV/FVV Device Order Form

PB16-53 Changes in the Home Health Prior Authorization Process for ABI Waiver Clients

PB16-52 Phase II Children's Dental Fee Schedule Reduction

PB16-51 Repairs and Modifications for Miscellaneous Wheelchair Components Billed Under Procedure Code K0108

PB16-50 Eligible Clients Under the Affordable Care Act Part V (Temporary ID Notice Update)

PB16-49 Implementation of the Milligram Morphine Equivalency (MME) Audit

PB16-48 Pricing of Complex Rehabilitative Technology Equipment for Manually Priced Codes

PB16-47 New Autism Spectrum Disorder Services

PB16-46 Reinstatement of Pharmacy Monthly Co-pay Maximum for Dual Eligible Clients

PB16-45 Phase I-Changes to the Children's Dental Fee Schedule for August 1, 2016

PB16-44 EVV Notification to Clients Receiving Services

PB16-43 CT DSS EVV Webinar Based Training

PB16-42 Provider Bulletin PB16-37 New Autism Spectrum Disorder Services Being Rescinded

PB16-41 EVV Training Important Information

PB16-40 Documentation and Billing Guidelines for Services Performed By Residents

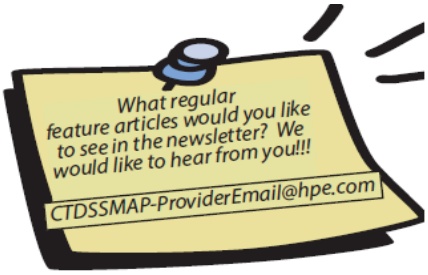
PB16-39 Mosquito Repellent Bulletin

PB16-38 Provider Qualification Process For Autism Spectrum Disorder Services

PB16-36 Opioid Legislation

PB16-35 Outpatient Hospital Modernization Behavioral Health Services

PB16-34 Guidelines for Observation for Medical and Behavioral Services



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