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

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

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- Hospice Providers: “High”/”Low” Explanation of Benefit (EOB) Codes
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Federally Qualified Health Centers (FQHCs)

Medicaid Claims Processing After Medicare and/or TPL Payments

Hewlett Packard Enterprise wants to remind Federally Qualified Health Center (FQHC) providers how Medicare crossover claims and/or claims with Third Party Liability (TPL) payment are reimbursed. Both Medicare crossover claims and/or claims with TPL payment are reimbursed at the full Medicaid clinic encounter rate for procedure code T1015 minus the Medicare and/or TPL payment. As a result, the Medicaid payment could be greater than or less than the coinsurance and/or deductible, copay or patient responsibility reflected on the Explanation of Medicare Benefits (EOMB) and/or TPL voucher.

Medicare crossover claims that do not automatically transfer to Hewlett Packard Enterprise for processing should be submitted to Hewlett Packard Enterprise electronically by the provider. Crossover claims must match the Explanation of Medicare Benefit (EOMB). This includes patient name, detail dates of service, procedure code(s), modifiers (if applicable), units, and billed amounts on each line. Crossover claims do not need to include the T1015 clinic encounter code.

TPL claims should be submitted to Hewlett Packard Enterprise electronically by the provider. Providers must bill using the T1015 clinic encounter code and the appropriate procedure code(s) that identifies the service(s) performed on subsequent lines.

For detailed instructions regarding how to submit Medicare crossover claims and/or TPL claims, refer to the "Professional Other Insurance/Medicare Billing Guide" available on our Web site www.ctdssmap.com. From the Home page, select "Information" then "Publications", scroll down to Provider Manuals, and select "Professional Other Insurance/Medicare Billing Guide" from the Chapter 11 drop down box.

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Hospice Providers

"High"/"Low" Explanation of Benefit (EOB) Codes

Do you need help determining if your routine home care (RHC) claim paid at the "High" or "Low" rate? Hewlett Packard Enterprise has created two (2) new Explanation of Benefit (EOB) codes that will help you understand the reimbursement of claims that contain details with revenue center code (RCC) 651 for dates of service January 1, 2016 and after.

Consistent with the Medicare Hospice payment reforms, Hospice providers are reimbursed a two-tiered payment for RHC for dates of service January 1, 2016 and forward. If the service day occurs during the first 60 days from the lock-in date, reimbursement will be equal to the RHC "High" rate; these details will post EOB code 9976 – "Pricing Adjustment – Metropolitan Statistical Area Pricing Applied", when the detailed billed amount is greater than the Metropolitan Statistical Area (MSA) allowed amount. If the service day occurs during days 61 and beyond, reimbursement will be equal to the RHC "Low" rate; these details will post EOB codes 9976 – "Pricing Adjustment – Metropolitan Statistical Area Pricing Applied" and 9967 – "MSA Low Rate Applied", when the detailed billed amount is greater than the MSA allowed amount. Providers are encouraged to bill their usual and customary charge when submitting claims to ensure maximum reimbursement. Details with dates of service prior to January 1, 2016 will continue to be reimbursed at the Default (DEF) rate reflected on the Hospice fee schedule that is in effect through December 31, 2015. As a reminder, RHC claim payments are calculated based on the date of the lock-in; therefore, if a client has a lock-in starting in 2015, the 2015 lock-in date is counted as day one (1) within the episode.

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To determine the rate and reimbursement for each county and associated town based on the regional rates listed on the Fee Schedule, providers should refer to the "Hospice Town/Metropolitan Statistical Area Regions Codes Crosswalk" located on the www.ctdssmap.com Web site. From the Home page, select "Information" then "Publications", scroll down to "Forms", then click on "Hospice Town/Metropolitan Statistical Area Regions codes Crosswalk" under "Hospice Forms". The numerical code listed under the "Regional Area or Metropolitan Statistical Area" column correlates with the numerical code listed under the "Region" column on the Hospice Fee Schedule. Please refer to Policy Transmittal 2016-03 and/or the Hospice Chapter 8 Provider Specific Claims Submission Instructions for additional information. To access the Hospice Chapter 8 from the www.ctdssmap.com home page, select "Information" then "Publications" scroll down to "Provider Manuals" and select "Hospice" from the Chapter 8 drop down menu.

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Outpatient Hospital Providers

Hospital Modernization Changes Scheduled for July 1, 2016

The Department of Social Services (DSS) is modernizing outpatient hospital reimbursement under the Connecticut Medical Assistance Program (CMAP) from the current model to an Outpatient Prospective Payment System (OPPS). Most claims for dates of service on or after July 1, 2016 will process with the APC grouper software, unless identified as an APC exclusion. Hospitals paid under OPPS will utilize CMAP's Addendum B to determine the method of payment for outpatient hospital services. The Department will maintain this file that lists each HCPCS and CPT code, the assigned status indicator, and the payment type under CMAP. Please refer to CMAP's Addendum B to determine which services will be reimbursed based on a fixed fee, fee schedule or APC assignment. CMAP's Addendum B can be accessed via www.ctdssmap.com Web site, and then select "Hospital Modernization" then "outpatient payment methodology," then go to "important message" and select CMAP addendum B.

The CMAP Addendum B excel file will be in the Important Message section and will have 3 tabs: 1) Addendum B version with the list of all the procedure codes, a short description, payment type, status indicator, APC code, relative weight and Connecticut Fee Schedule. 2) Addendum B legends with field descriptions and valid values. 3) CT Fee Schedule legend with the fee schedules and descriptions. Details paid off of CT Fee Schedule are based on the HCPCS/CPT codes. CT fee schedules can be accessed and downloaded by going to www.ctdssmap.com website. From this page, go to the Hospital Modernization page and on the right side under Helpful Information and Publications click on "CT Fee Schedule", click on the "I accept" button then select the appropriate fee schedule.

Some claims may have an APC packaged service status indicator which will mean that individual details will not separately pay since the payment for the packaged service is included in payment of another APC detail. In addition to a base detail APC price, details can be impacted by a discount factor and outlier threshold values. Outlier payment adjustments will be made on claims with outpatient services with significant costs. The hospital outlier policy is calculated on a service basis using both fixed-dollar and multiple thresholds to determine outlier eligibility.

The base formula for determining APC payments is calculated by multiplying the Hospital Wage Adjusted Conversion Factor X Units X APC Weight. For example, to calculate the APC payment for APC 5023 (Emergency department visit) Current Procedural Terminology (CPT) 99283:

Base APC Payment = (Provider Wage Adjusted Conversion Factor * units) * APC Weight.
Base APC Payment = (82.74*1) * 2.6582
Base APC Payment = $219.94

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In order to bill for outpatient professional services, Hospitals should be prepared for the changeover by making sure at least one hospital based practitioner group is enrolled in the Connecticut Medical Assistance Program (CMAP). If the hospital has already enrolled a practitioner group as directed by provider Bulletin 2014-68 "Hospital Based Practitioners-Inpatient Services", they are not required to enroll as a separate group. Please refer to our website www.ctdssmap.com under "Information" "Publications" Provider Bulletin 2016-06 "Hospital Based Practitioners - Outpatient Services", for more information on enrolling hospital based practitioner groups. Please note: not all professional services rendered will have a separately payable professional component.

The following services will be excluded in the APC pricing methodology and these services will reimburse based on a fixed fee, which includes the following Revenue Center Codes (RCCs):

Service	RCC
Diagnostic Mammography	401
Screening Mammography	403
Physical Therapy	421, 424
Occupational Therapy	431, 444
Speech Therapy	441, 444
CARES	769
Vaccine Administration	771
Electro Shock	901
Tobacco Cessation- Group Counseling	953

The following Behavioral Health RCC's will also be excluded; reimbursement will be driven by HCPC/CPT code and will pay based on the Clinic and Outpatient Hospital Behavioral Health Fee Schedule:

Service	RCC
General BH	900
Individual BH Therapy	914
Group BH Therapy	915
Family BH Therapy	916
Psychiatric Testing	918
Other BH (medical management)	919

Comprehensive information on Outpatient Hospital Modernization and payment reimbursement can be found at www.ctdssmap.com by selecting the "Hospital Modernization" Web page. This page will provide details regarding FAQs, the Provider Type and Specialty to RCC Crosswalk, Provider Publications and Hospital Important Messages. Please refer to this page periodically for updates.

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

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Attention Dental Providers

Do you know what Explanation of Benefit (EOB) Code 9992 "Payment Amount Reflects Tooth Surface Pricing" setting on your claim means?

"In accordance with the Dental Regulations [184E.I.c.2.(c)], the Connecticut Medical Assistance Program does not reimburse for the restoration of separate surfaces when treatment is performed on a single tooth by the same provider (on the same tooth, for the same provider). Dental providers will be reimbursed for the total number of surfaces restored on a single tooth per one year period for each provider."

Effective July 1, 2015, the Department of Social Services (DSS) reminded all dental providers regarding the above policy communicated in Provider Bulletin PB 2014-62 with regards to reimbursing for the total number of surfaces restored on a single tooth per one year period for each provider. For example, a provider was paid for restoration on tooth 19 for surfaces M (Mesial) and O (Occlusal); the same provider submits

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a second claim for the same client within one year from the previous date of service for restoration on the same tooth for surfaces D (Distal) and O (Occlusal). The second claim will not pay for a second two surface restoration but will pay the difference between the two surface and the three surface restoration and post Explanation of Benefit(EOB) code 9992 - Payment Amount Reflects Tooth Surface Pricing at the detail.

If there happens to be a scenario where a tooth fractures and needs to be restored within a year of the previous filling, providers can request prior authorization through the Connecticut Dental Health Partnership (CTDHP). This service will be paid at the full fee schedule rate in this case based on medical necessity. Providers can apply for prior authorization by logging into their account at www.ctdhp.com or by contacting CTDHP Provider Relations at 1-888-445-6665 Monday through Friday, from 8:00 a.m. to 5:00 p.m.

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Attention All Providers

Electronic Funds Transfer (EFT) Requirement Reminders

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 EFT has been enrolled. 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 scroll 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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Pharmacists Certified to Prescribe Narcan

Changes to Narcan Prescribing
Substance Abuse and Opioid Overdose Prevention

Pursuant to Connecticut Legislation, Public Act 15-198, An Act Concerning Substance Abuse and Opioid Overdose Prevention, as part of the initiative to combat prescription opioid and heroin abuse, pharmacists who have been certified have been given the ability to prescribe naloxone (brand name Narcan®).

Effective March 30, 2016, certified pharmacists may submit their National Provider Identifier (NPI) as the prescribing provider's NPI on claims submitted to the Connecticut Medical Assistance Program (CMAP).

Alternatively, when the certified pharmacist prescribing naloxone has not registered with the National Provider Plan and Enumeration System (NPPES) for an individual NPI, the pharmacy dispensing naloxone may submit the NPI of the pharmacy as the prescribing provider's NPI on the pharmacy claim for naloxone. In that instance, the name of the trained and certified pharmacist must be clearly documented on the naloxone prescription. Verification of pharmacist certification will be done outside of the claim processing system via the Quality Assurance pharmacy audit process.

Only Narcan 4mg Nasal Spray (NDC 69547-0353-02) and covered NDCs of naloxone syringe are reimbursable.

At this time, Evzio 0.4mg Auto-Injector (NDC 60842-0030-01) is the only non-preferred naloxone and will deny if prescribed by a licensed pharmacist. Since Evzio is subject to the Preferred Drug List (PDL), only an enrolled prescriber (not pharmacist or pharmacy) may submit a prior authorization request.

Additionally, scripts for naloxone and Narcan prescribed by pharmacists are not subject to the tamper-resistant prescription pad requirement.

Information regarding training and certification for pharmacist prescribers and dispensers of naloxone can be accessed by going to the Department of Consumer Protection's (DCP) Web site: http://www.ct.gov/dcp/cwp/view.asp?a=1620&pm=1&Q=570042. .com.

For more information, please refer to the Provider Bulletin 2016-11.

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Attention Connecticut Home Care (CHC), Personal Assistance (PCA), Community First Choice, and Home Health Agency Providers

Access Agency contact information for Care Plan resolution

Providers are encouraged to use the following Access Agency contact information for the resolution of Care Plan issues. Please note required information that should accompany inquiries to expedite the resolution.

- **Connecticut Community Care (CCCI)**
  serviceauthissues@ctcommunitycare.org

Providers must include the following information when submitting service authorization issues to CCCI: provider name, client name, client EMS number, CCCI number, Explanation of Benefit (EOB) code on rejecting claim at Hewlett Packard Enterprise, from and to dates of service, the type of service (adult family living/foster care, support broker services, CFC or home health services), the frequency of service (spanned dates, monthly or weekly), the number of units needed, CCCI service order number, if available, and any comments the provider wishes to communicate to CCCI.

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- **South Western Connecticut Area on Aging (SWCAA)**
  SWCAABillings@swcaa.org

Please have the following information available when contacting SWCAA: client name, the client EMS number, the type of service (adult family living/ foster care, support broker, CFC or home health services), the dates of service, the frequency of service and the number of units or hours per visit.

- **Agency on Aging of South Central CT (AASCC)**
  chcbilling@aoascc.org

Companies without secure e-mail, please fax service order inquiries to (203) 752-3064. Due to the high volume of inquiries, AASCC requests your primary source of communication to them be by e-mail or fax.

- **Western Connecticut Area on Aging (WCAA)**
  Contact WCAA directly at (203)465-1000

Please have the following information available when contacting WCAA: client name, the client EMS number, the type of service (adult family living/ foster care, support broker services, CFC or home health services), the dates of service, the frequency of service and the number of units or hours per visit.

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Primary Care Physicians Delivering Family Medicine, General Internal Medicine or Pediatric Medicine

Are you receiving enhanced rates but unsure of which one?

Are you receiving an enhanced rate on your Medicaid claims, but are unsure of which one you are getting? Here is clarification on two of our enhanced rates.

HUSKY Health Increase Payment Policy (Formally known as (ACA) Enhanced Payment): Reimbursed for Evaluation and Management services to qualified providers at a rate that would be paid for the services (if the service were covered) under Medicare. The higher payments apply to primary care services delivered by a physician who has self-attested to a covered specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists who attest and are within those designations as recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) and/or that 60 percent of their Medicaid claims for the prior year were for the E&M codes specified in the regulation. This enhanced payment is also denoted on an electronic claim with the following possible Explanation of Benefits (EOB).

EOB 9964 - PRICING ADJUSTMENT - ACA MAX FEE PRICING APPLIED
EOB 9965 - ACA ENHANCED RATE ADD ON

The EOB panel of your claim will look similar to this:

EOB

View

Detail Number	EOB Code	EOB Description	Financial Payer
1	9964	PRICING ADJUSTMENT - ACA MAX FEE PRICING APPLIED	

Person-Centered Medical Home (PCMH) Initiative: Under the PCMH initiative, practices/clinics that demonstrate a higher standard of person-centered primary care service qualifiy for a higher level of reimbursement for said primary care services from the Department of Social Services. This program is administered through the Department's Administrative Services Organization – Community Health Network (CHN) and to qualify both the practice/clinic AND the individual rendering service must both be PCMH approved.

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The incentive payment is directly linked to the address submitted on your claims. This means, if your location changes, you can NOT use the secure Web portal to change your location's address. To change or update this information, you will have to get in touch with your CHN representative to properly update your location and send a letter, on your business letterhead, to Hewlett Packard Enterprise written correspondence. PCMH will be denoted on an electronic* claim by the following possible EOBs:

EOB 9975 - PRICING ADJUSTMENT - PCMH PERCENTAGE RATE APPLIED

EOB 9972 - PRICING ADJUSTMENT - PCMH PARTIAL OR NO PERCENT RATE APPLIED

The EOB panel of your claim will look similar to this:

EOB

View

Detail Number	EOB Code	EOB Description	Financial Payer
1	9975	PRICING ADJUSTMENT - PCMH PERCENTAGE RATE APPLIED	DEF

*Paper claims can not be submitted to receive the PCMH rate.

Providers of Cognitive Behavioral Services

DSS changes to ABI Waiver Programs

This is a reminder that the Department of Social Services (DSS) will be making changes to the administration of the Acquired Brain Injury (ABI), ABI I and ABI II Waiver programs which are targeted for claims with dates of service September 1, 2016 and forward. Self-employed Individuals of Cognitive Behavioral services and all Agencies providing services to ABI Waiver clients must enroll in the Connecticut Medical Assistance Program (CMAP) with a provider type of "Acquired Brain Injury" and specialty of "ABI Service Provider" in order to receive reimbursement for services rendered on or after September 1, 2016.

ABI Waiver providers who have been credentialed by Allied Community Resources to provide services may begin enrolling as "ABI Service Providers" effective immediately, including ABI Self Employed Service Providers. Providers are encouraged to begin enrolling now, as the enrollment process may take up to four (4) weeks or more to finalize.

Workshops were held at the end of April for providers to review the online application process for enrolling as an ABI Service Provider, including available resources. For those who were unable to attend, the workshop is available on our Web site www.ctdssmap.com. From the Home page, select "Provider", and then "Provider Services". Scroll to the bottom of the page and click the "here" link. Next, click ABI Service Provider Workshops, under Provider Training, then select ABI Service Provider Enrollment on the Web.

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In-Home Care Providers

Electronic Visit Verification: In-home visit scheduling, tracking and billing system

Hewlett Packard Enterprise has partnered with Sandata Technologies, LLC to provide Electronic Visit Verification (EVV) services under the existing MMIS contract with the Connecticut Department of Social Services (DSS).

EVV is an in-home visit scheduling, tracking and billing system that employs controls within the delivery of home based services to ensure client's quality of care.

DSS has recently finalized the list of services which will be implemented into Electronic Visit Verification(EVV). DSS' EVV system must be used for the list of mandated services for clients enrolled in the Connecticut Home Care, PCA and ABI Waiver Programs. Home Health services, such as skilled nursing, medication administration, home health aide and therapy services provided to clients enrolled in HUSKY only, are not included in this implementation.

The list includes both mandated and optional services. The full list can be located as a link in the most recently updated EVV Important Message or you can log on to the www.ctdssmap.com Web site, click the "Information" tab, and locate the Important Message Electronic Visit Verification Implementation at the top of the page.

From here, you can also access a link to the Frequently Asked Questions (FAQ) document and the "Introduction to Electronic Visit Verification "workshop presentation from November.

Also, be on the lookout for new EVV updates including an updated timeline for implementation and an introductory webinar which will provide an introduction to the Department's EVV system. For any questions or concerns related to the Department's EVV implementation, please direct your inquiries to DSS/ Hewlett Packard Enterprise at ctevv@hpe.com.

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Appendix

Holiday Schedule

Date	Holiday	HPE	CT Department of Social Services
7/4/16	Fourth of July	Closed	Closed
9/5/16	Labor Day	Closed	Closed
10/10/16	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.

PB16-33 EVV Third Party Interface
PB16-32 Billing Clarification or Brand Name Medications on the Preferred Drug List (PDL)
PB16-32 July 1, 2016 Changes to the Connecticut Medicaid Preferred Drug List (PDL)
PB16-32 Reminder About the 5 Day Emergency Supply
PB16-31 Elimination of Paper Claims Notification
PB16-30 Private Non-Medical Institution (PNMI) Rates for Adult Mental Health Rehabilitation Services
PB16-29 EVV Introductory Webinar Registration Now Open
PB16-28 Billing for Customized Wheelchairs
PB16-27 Changes to the Children's Dental Fee Schedule Reimbursement Rate
PB16-26 Home Health Medication Administration Reimbursement Reduction
PB16-25 Update Regarding Outpatient Hospital Modernization - Outpatient Prospective Payment System (OPPS)
PB16-24 Updated Timeframe for Requesting Authorization for Retroactive Eligibility
PB16-23 Introduction to the Department of Social Services Electronic Visit Verification Implementation HIPAA Compliant Update
PB16-22 New National Drug Code Requirements for Manually Priced Vaccines and Toxoids
PB16-21 DMHAS Performing Provider Re-Enrollment Notification
PB16-20 Discontinue Use of Expired Form W-1HUS (HUSKY Application and Renewal Form)
PB16-19 New HUSKY D Medicaid Procedures for Individuals Needing Long-term Services and Supports (LTSS)
PB16-18 Payment for Inpatient Hospital Care Provided to Inmates
PB16-17 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health and CADAP Programs)
PB16-16 Changes to Prior Authorization Requirements for Advanced Imaging and Nuclear Cardiology Services
PB16-15 Important ABI Waiver Provider Enrollment and Claim Submission Changes for Providers of ABI Waiver Services under the ABI Waiver Program
PB16-14 Expedited Medicaid Eligibility Processing for Individuals with Medical Emergencies
PB16-13 Medicare Cost Reports
PB16-12 Hospital Billing and Reimbursement for Immediate Postpartum Long-Acting Reversible Contraceptive Products
PB16-11 Clarification of Changes to Narcan Prescribing
PB16-10 Prescribing of Opioid Antagonists by Certified Pharmacists
PB16-09 Notification of Federal Upper Limit Changes
PB16-08 Targeted Case Management for Adults with Serious and Chronic Mental Illness or Substance use Disorders

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