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

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- How to Avoid Critical Errors When Completing Web Applications
- Hewlett Packard Enterprise Services Has Become Hewlett Packard Enterprise
- 3 Day Rule for Hospitals: Outpatient Stay Prior to Inpatient Admission
- Take Action! Time is Quickly Running Out to Apply for the Connecticut Medicaid Electronic Health Records (EHR) Incentive Payment Program!

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How to Avoid Critical Errors When Completing Web Applications

Frustrated with receiving critical errors when completing a Web application? Here are some helpful hints to avoid some commonly made mistakes that lead to critical errors:

1. When completing the Board Members, Partners, or Managing Administrators Information section, it is important to know the following. Whenever the ADD button is selected, the system creates a blank row in order for data to be entered. If there is an extra, or more than one extra, blank row, and data is not inputted, when the user selects NEXT to continue with the application, they will receive a critical error message.

   Therefore, do not click on the ADD button when inputting your first entry. The system gives you the initial blank row for your entry without you needing to click ADD. Only click on the ADD button if you have more than one entry to make.

   If an extra row(s) is/are created, take the following steps to clear the extra row so you may proceed with your application:

   a. Click on the row which is in error, then press the DELETE button. Each blank row, if more than one, will need to be removed before you are able to move to the next panel.

2. Whenever you are being asked to enter a number, such as a Social Security Number (SSN), Date of Birth, percentage of ownership/controlling interest, etc., do not enter any dashes (-), slashes (/), or a percent sign (%) after your entries. If these special characters are entered, the user will receive a critical error message.

   To clear the error, go back through your application and remove any of these special symbols where they were entered.

3. Have you received the, "The Name and/or SSN on the Individual Name section and Summary section do not match? Please either update the information to make the name and the SSN match exactly in both sections of the application; or, provide unique data in each section of the application," message.

   The SSN and the Signature on the Summary panel is verified against the Individual Name & Identifying Information panel. The information on these two panels must be uniquely different (different names and different SSNs); or, the information must be an exact match between the two panels. This includes hyphens in the name field. To avoid this error:

   a. Ensure the data in both panels match, or are unique from one to the other. If the data on both panels should be the same and you do receive the error, make sure that you entered the name exactly the same in both panels.

   b. Ensure that you have not entered any special symbols in either the name fields or the SSN fields in either panel. If you have, remove them.

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Hewlett Packard Enterprise Services Has Become Hewlett Packard Enterprise

On November 1, 2015, Hewlett Packard split into two separate companies, HP, Inc. and Hewlett Packard Enterprise.

Many providers are asking, will this have any impact? Providers probably won't notice many changes. Providers have begun to see the Hewlett Packard Enterprise logo or the Hewlett Packard Enterprise name on correspondence. Providers also began to receive emails from the @hpe.com email address rather than the @hp.com email address. And, finally, providers hear the Hewlett Packard Enterprise name when calling the Provider Assistance Center.

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Enhancements to Archived Messages

Hewlett Packard Enterprise is pleased to announce enhancements for Important Messages and Remittance Advice (RA) Banner Announcements that are archived. The method to access archived messages has not changed. To access archived messages, providers may either:

- From the Home page, select the link for Archived Messages from the drop-down menu under Information.

OR

- From the Home page, scroll down to the bottom of the Important Message and select the link titled "Click here for Archived Messages"

OR

- From the Home page, select the quick link to RA Banner Announcements on the left hand side under Information. From this panel, select the link titled "Click here for Archived RA Banner Announcements". The Messages Archived panel will be displayed.

However, once the Messages Archived panel is now displayed, archived messages will be displayed by year, with archived messages for the current year displayed from most recent to oldest effective date. Previous years archived messages will be collapsed, but can easily be expanded by selecting the + sign when searching for necessary information.

Additionally, a keyword search functionality has been added. When searching archived Important Messages, the keyword entered in the search box will be used to search within titles of an Important Message to aide in finding required information. When searching archived RA Banner Announcements, the keyword entered in the search box will be used to search within titles as well as the body of announcements to aide in finding required information. Providers continue to have access to Important Messages and RA Banner Announcements posted from January 1, 2014 forward.

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Disabling Safari Pop-up Blocker to Avoid Downloading Issues

If you are using the Safari Web browser and are experiencing difficulty downloading Remittance Advices (RAs) and other documents from the www.ctdssmap.com Web site, we recommend disabling pop-up blockers to enable these functions to operate successfully. The following options are available in order to disable/enable pop-up blockers for Windows, MAC, and iPad users:

Option 1:
1) Select the **settings gear** in the upper- right corner.
2) Select "**Block Pop-Up Windows**". When the option is checked, pop-ups are blocked.

Option 2:
1) Press **"Ctrl" + "Shift" + "K"** in Windows or **"Command" + "Shift" + "K"** in OS X to toggle between blocking and not blocking pop-ups.

Option 3:
1) Windows users select the **settings gear**, then choose "**Preferences**". Mac users click **"Safari" > "Preferences"**.
2) Click on "**Security**" at the top of the window.
3) Check the box "**Block pop-up windows**" to enable this feature. Uncheck it to disable it.

iOS Version:
1) From the Home screen, select "**Settings**".
2) Choose "**Safari**".
3) Slide the "**Block Pop-ups**" to "**On**" (green) to block pop-ups, or slide it to "**Off**" (white) to never block pop-ups.

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Hewlett Packard Enterprise Transitions from Virtual Room to MyRoom for Webinars, Effective August 15, 2015

On August 15, 2015, Hewlett Packard Enterprise transitioned our webinar tool from Virtual Room to MyRoom. For all practical purposes, the format and technology is basically the same. However, for your initial webinar you will need to take the time to download/set up MyRoom for any upcoming virtual workshops that you register for prior to the event. Once downloaded for your initial webinar, you will be able to register as you did previously for future webinars.

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Provider File Maintenance

In order to maintain the accuracy and completeness of the Connecticut Medical Assistance Program (CMAP) network, we are requesting all providers update their provider file on a regular basis. The information that you provide is presented in the on-line provider directory at www.huskyhealth.com. Thousands of members statewide rely on the accuracy of this source of information to find a suitable health care provider. Inaccurate addresses, phone numbers, and names may affect a member's ability to contact you. To update your provider profile, the main account administrator can log into their secure Web account from the www.ctdssmap.com Web site and click on the "Demographic Maintenance" tab. Once on the Demographic Maintenance page, the provider can select from options listed as links below the Demographic Maintenance header panel. For instance, you can update your address* if you happen to move to a new location; all you have to do is click on the "Location Name Address" link, select the address to be updated, click on the "Maintain Address" button to type in the new address and then save your changes. You can also add or remove performing providers to your group practice as applicable by clicking on "Maintain Organization Members". For detailed instructions, please refer to Section 10.18 "Provider Demographic Maintenance" in Chapter 10 of the Provider Manual. The chapter is available from the Web site www.ctdssmap.com by clicking on "Publications" under Information, scrolling down to Provider Manuals and then clicking on "Web Portal/AVRS". You may contact the Provider Assistance Center at 1-800-842-8440 between the hours of 8:00 AM to 5:00 PM Monday through Friday if further assistance is needed in updating the information from your secure Web account.

*There are special instructions for PCMH providers and clinic providers for updating their service location or alternate service location addresses. Please refer to Chapter 10 for additional information.

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3 Day Rule for Hospitals: Outpatient Stay Prior to Inpatient Admission

The Department of Social Services (DSS) is implementing the **3 Day Rule** on outpatient claims when a date of service is within 3 days (2 days plus the admission date) prior to an inpatient admission. This affects all hospital admissions for all diagnostic and non-diagnostic outpatient services including psychiatric diagnostic services on or after November 1, 2015. DSS is implementing new Explanation of Benefit (EOB) codes. EOB codes **5077** "Inpatient stay denied due to a paid outpatient claim within 3 days prior to inpatient admission" or **5078** "Outpatient claim denied due to a paid inpatient claim within 3 days after an outpatient claim" is set up initially for post and pay status. The **post and pay status** means the edit will be shown on the claim but the claim is not denied for that reason. The EOB code will post to the hospital's Remittance Advice.

The post and pay status will help hospitals identify claims that start denying for admissions on or after July 1, 2016 if the outpatient claim is billed separately and not billed with the inpatient stay. There are exceptions to the rule. Maintenance renal dialysis services billed with revenue center codes (RCC) 82X, 83X, 84X and 85X are excluded and will not post either EOB code 5077 or 5078 even if billed 3 days prior to an inpatient admission. Physical therapy, occupational therapy, speech therapy and audiology services billed under RCCs 42X, 43X, 44X and 47X are also excluded from the 3 day rule. Behavioral health services of Intensive Outpatient Services (IOP), Partial Hospital Program (PHP), or routine psychotherapy services billed under RCCs 901, 905-907, 913 and 914-916 are also excluded.

If the hospital is able to attest that the outpatient claim is unrelated to the inpatient hospital claim and are clinically distinct and independent from the reason for admission, the hospitals should bill with condition code 51 "Attestation of Unrelated Outpatient Non-diagnostic Services" that are not related and for which separate reimbursement is appropriate.

When Outpatient Hospital Modernization is implemented, for any hospital outpatient admissions on or after July 1, 2016, the hospitals are required to bill all related outpatient services within 3 days prior to inpatient admission on the inpatient claims. Once the post and pay period ends, the outpatient or inpatient claim will begin to deny payment with either EOB code 5077 or 5078.
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Hospital Providers

Ambulatory Payment Classification (APC) Scheduled for July 1, 2016

DSS will move from the current system of hospital outpatient payment methodology based on Revenue Center Codes, (some paid based on fixed fees, some based on a ratio of costs to charges) to a prospective payment system based on the complexity of services performed. This change is scheduled for July 1, 2016.

The reasons for the move to APCs is to streamline policy to be consistent with industry standard payment practices (specifically, Medicare payment policy) and maintain a long-term commitment to goals of improved accuracy, predictability, equity, timeliness, and transparency of hospital payments for all Medicaid beneficiaries.

Hospitals can refer to the Hospital Modernization Web page on the www.ctdssmap.com Web site for information pertaining to the APC implementation.

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Home Health and CHC Access Agencies

Linking Home Health VO Service Authorizations to the CHC Care Plan

As a reminder, Value Options (VO) service authorizations, obtained by Home Health Agencies for clients with a Connecticut Home Care Program for Elders (CHCPE) benefit plan, must be added to the client's CHCPE Care Plan by the Access Agency care managing the client. Home Health and CHC Access Agencies should implement internal procedures to comply with their responsibilities to ensure a client's VO service authorization is linked to their Care Plan in a timely manner to prevent prior authorization (PA) file upload issues and claim denials.

Home Health Agencies are currently responsible for:

Obtaining the service authorization from VO

- Communicating current VO PA information to the Access Agency Care Manager when asked to provide services to a client with a CHCPE benefit plan
- Contacting VO to end date the current PA and issue a new PA when notified by the Access Agency that the client's current CHCPE care plan is being end dated and a new Care Plan is being established

The Access Agency is currently responsible for:

- Determining if a VO PA already exists when requesting a Home Health Agency provide services to a CHCPE client
- Linking the client's VO PA to the Care Plan prior to uploading the Care Plan to Hewlett Packard Enterprise
- Notifying the Home Health Agency prior to end dating a current care plan and establishing a new care plan, allowing the Home Health Agency to notify VO to end date the current PA and issue a new PA which must then be linked to the new Care Plan

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Hospice Rate Update Changes Effective January 1, 2016

The Centers for Medicare & Medicaid Services (CMS) recently announced updates to the Hospice payment rates for fiscal year (FY) 2016. These changes will impact hospice providers with claim dates of service on or after January 1, 2016. These changes include a service intensity add-on for patients in the last seven (7) days of life during a hospice election and two tiers of Routine Home Care (RHC) per diem rate payments; one payment for days one (1) through 60 at the "high" rate, while days 61 + will be paid at the RHC "low" rate.

Service Intensity Add-On Payment (SIA)

Hospice services with dates of service on or after January 1, 2016 will be eligible for an end of life (EOL) SIA payment in addition to the current per diem rate for the RHC level of care if the following criteria are met:

- The day billed is an RHC level of care day.
- The day occurs during the last seven days of life and the patient status is expired.
- The service is provided by a registered nurse (RN) or social worker that day for at least 15 minutes (one unit), not exceeding 4 hours total (16 units).
- The service cannot be provided by a social worker via telephone.

This SIA payment will be paid at the hourly continuous home care (CHC) rate divided by four multiplied by the number of units. This reimbursement will be paid according to the geographic regions.

Routine Home Care (RHC) Per Diem Rates

Hospice services with dates of service on or after January 1, 2016 will be paid one of two RHC rates if the following criteria are met:

- The day billed is an RHC level of care day.
- If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC "High" Rate.
- If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC "Low" Rate.
- For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice may bill at the high or low RHC rate, upon hospice re-election.
- For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient's 60-day window, paid at the RHC "High" rate upon the new hospice election.

The reconfigurations to our system that are necessary in order to support the end of life SIA reimbursement will be implemented on or around April 1, 2016. Upon successful implementation, providers will be able to submit claims with dates of service retroactive to January 1, 2016 and forward for the additional SIA reimbursement.

The reconfigurations to our system that are necessary in order to support the new two tier payment reimbursement for RHC will also be implemented on or around April 1, 2016. Once these system changes are in place, the changes will be retroactive to January 1, 2016. A mass adjustment of paid claims will later occur to ensure that providers are reimbursed correctly. Providers are reminded that this mass adjustment may result in a lower payment for RHC paid claims with days 61 +.

Stay tuned! To prepare for these upcoming changes and to ensure an understanding of how your claims will be impacted, Hewlett Packard Enterprise with DSS will publish future notifications that will summarize and expand upon the above said changes that will prepare you for successful claims submission.

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Take Action! Time is Quickly Running Out to Apply for the Connecticut Medicaid Electronic Health Records (EHR) Incentive Payment Program!

The purpose of the Connecticut Medicaid EHR Incentive Payment Program is to encourage providers, with incentive payments, to implement a Certified EHR system and to use Health Information Technology within their operations. Eligible Providers (EPs) for the Connecticut Medicaid EHR Incentive are:

- Physicians
- Pediatricians
- Nurse Practitioners
- Certified Nurse Midwives (CNM)
- Dentists
- Physician Assistants (PA) – in a PA led FQHC

Eligibility: To be eligible for the EHR incentive payments, EPs have to meet a minimum threshold of Medicaid Patient Volume, within a 90-day Period.

- 30% (20% for pediatricians)

Stages: The different stages of the Program are as follows:

- Adopt, Implement, Upgrade to a certified EHR technology
- Meaningful Use Stage 1 – Data Capture and Information Sharing
- Meaningful Use Stage 2 – Advanced Clinical Practices (Clinical Decision Support)
- Meaningful Use Stage 3 – Improved Outcomes

The incentive payments are spread over 6 years. See the following timetable of Incentive Payments:

	Medicaid EPs who begin meaningful use of certified EHR technology in--					
Calendar Year	2011	2012	2013	2014	2015	2016
2011	$21,250	----------	----------	----------	----------	----------
2012	$8,500	$21,250	----------	----------	----------	----------
2013	$8,500	$8,500	$21,250	----------	----------	----------
2014	$8,500	$8,500	$8,500	$21,250	----------	----------
2015	$8,500	$8,500	$8,500	$8,500	$21,250	----------
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	----------	$8,500	$8,500	$8,500	$8,500	$8,500
2018	----------	----------	$8,500	$8,500	$8,500	$8,500
2019	----------	----------	----------	$8,500	$8,500	$8,500
2020	----------	----------	----------	----------	$8,500	$8,500
2021	----------	----------	----------	----------	----------	$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

**Pediatricians who meet 20% Medicaid patient volume but fall short of 30% receive $14,167 in year 1 & $5,667 in years 2 -year 6.

2016 is the absolute last year that you can apply to participate in Connecticut Medicaid's EHR Incentive Program. Act today to find out more information about the program and register to receive the payments.

Want More Information? To obtain more information and to register for the EHR Incentive Program, visit:

- DSS Health Information Technology: http://www.ct.gov/cthealthit
- Center for Medicare and Medicaid Services Registration: https://ehrincentives.cms.gov/hitech/login.action
- DSS EHR Incentive Program Registration: https://www.ctdssmap.com/CTPortal/Provider/EHRIncentiveProgram/tabid/55/Default.aspx

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Behavioral Health Clinicians

CMS National Correct Coding Initiative (NCCI) Implementation

To comply with federal legislation, the Department of Social Services (DSS) has adopted the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) standard payment edits. Behavioral health clinicians were inadvertently omitted from the initial policy transmittal PB 2011-12, CMS National Correct Coding Initiative (NCCI).

This newsletter article provides a reminder to behavioral health clinicians that DSS previously implemented the following NCCI edit:

> **Procedure code to procedure code edits** – This defines pairs of HCPCS/CPT codes that should not be reported together on the same date of service for a variety of reasons and result in the denial of reimbursement for one or both procedures. Procedure code to procedure code edits were implemented effective January 1, 2013 for behavioral health clinicians.

Please be aware that the NCCI edits are designed to promote correct coding and to control improper coding that could lead to inappropriate payments. Visit the CMS Web site http://www.cms.gov/NationalCorrectCodInitEd/ for instructions on how to use NCCI, how to locate the NCCI Table Manual, how to look up procedure code to procedure code edits, and the use of bypass modifiers.

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Appendix

Holiday Schedule

Date	Holiday	HPE	CT Department of Social Services
1/1/2016	New Year's Day	Closed	Closed
1/18/2016	Martin Luther King Jr. Day	Closed	Closed
2/12/2016	Lincoln's Birthday	Open	Closed
2/15/2016	President's Day	Closed	Closed
3/25/2016	Good Friday	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.

PB15-95 January 1, 2016 Changes to the Connecticut Medicaid Preferred Drug List (PDL)
PB15-95 Reminder About the 5 day Emergency Supply
PB15-95 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)
PB15-94 Medication Administration Savings Expectations for Fiscal Years 2016
PB15-93 Changes to Prior Authorization Requirement for Selected Codes on Physician Fee Schedule
PB15-92 Medications for Substance Use Disorders
PB15-91 Update to Revenue Center Codes (RCC) Requiring a Valid CPT or HCPCS on Outpatient Claims
PB15-90 Additional Billing Guidance for New Medication Administration Prompt Code
PB15-89 Additional Expansion of Coverage For Over The Counter (OTC) Products
PB15-88 Clarification of Ambulance Mileage Procedure Codes
PB15-87 Outpatient Hospital Modernization - Outpatient Prospective Payment System (OPPS)
PB15-86 CMS National Correct Coding Initiative (NCCI)
PB15-85 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health and CADAP Programs)
PB15-84 Changes to the Ambulance Fee Schedule (Emergency and Non-Emergency)
PB15-83 New Prior Authorization Request Form for Orkambi
PB15-82 Three (3) Day Rule: Outpatient Stay Prior to Inpatient Admission
PB15-81 Rate for Live-In Person Care Assistant Service
PB15-80 Fee Schedule Update for Behavioral Health Clinics
PB15-79 Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Primary Care
PB15-78 Important - Withdrawal of Extended Nursing Services Policy
PB15-77 Increase in Hospice Rates
PB15-76 Changes to the Obstetric (OBS) and Facility Obstetric (FTO) Rate Types
PB15-75 Addition of New Medication Administration Prompt Code
PB15-73 Decrease in Current Rate for Code G0431
PB15-72 Multi-disciplinary Examinations
PB15-70 Developmental and Behavioral Screens in Primary Care
PB15-69 Autism Spectrum Disorder (ASD) Evaluation and Treatment Services Provided by Medical Clinics, Rehabilitation Clinics and Board Certified Behavior Analysts
PB15-68 Changes to the Physician Office and Outpatient Fee Schedule

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