April 2020
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- All Providers: What is Pre-Notification Status?
- Waiver Service Providers: Renewal of Acquired Brain Injury (ABI) Waivers
- All Providers: 1099s Are Now Available on the Connecticut Medical Assistance Program Web Site
- All Providers: Your Free Training Resources
- Waiver Providers: Common Explanation of Benefits (EOB) and How to Resolve them For Waiver Providers
- All Providers: Connecticut Medical Assistance Program COVID-19 Response

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Attention: All Providers

Submitting Medicare Advantage Plan Crossover Claims To CT Medicaid

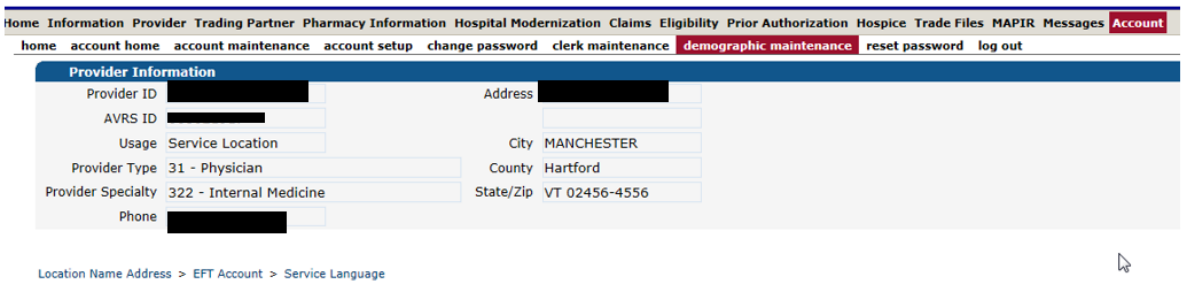
To submit claims to the Connecticut Medical Assistance Program (CMAP) for payment of previously adjudicated claims from a Medicare Advantage plan where there was a co-payment, the Claim Adjustment Reason Code (CARC) of 3 for co-payment should not be used. The use of the CARC 3 will result in the claim being processed as a straight Medicaid claim and will deny for "Bill Medicare first". Providers should use CARC 2 for co-payment amounts. **The CARCs of 1 for deductible, or 2 for co-insurance are the only CARCs that will result in the creation of a crossover claim type for CT Medicaid.**

Attention: All Providers

What is Pre-Notification Status?

Have you recently changed your bank information through the Connecticut Medical Assistance Program (CMAP) Web site? Are you enrolling and setting up your direct deposit? If so, you might be wondering what a pre-notification status means.

Any time you make changes to your financial information through the CMAP Web site, you are automatically placed in a pre-notification status. This means, until that information is verified by your bank, you will be receiving paper checks in the mail. This is important to note because you should always verify the correct address is listed in your Demographic Maintenance panel BEFORE making any changes to your financial information. That way it can be assured the paper checks will be sent to the proper location for reimbursement. The EFT panel can be accessed by the provider by logging into their secure Web account, selecting "Demographic Maintenance" and clicking the blue hyper-link labeled "EFT Account" located just below the populated "Provider Information".



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Attention: Waiver Service Providers

Important Billing Reminders for Waiver Service Providers

Waiver Service Providers that bill directly to DXC Technology are reminded of the following:

- Providers enrolled as Service Providers in multiple Waiver programs must be actively enrolled as a Waiver Service provider in the Waiver program of the client for whom services are being billed.

- If enrolled as a Service Provider in multiple waiver programs, it is important to be logged into the secure Web account of the Waiver program for which you are submitting claims, either via direct login or via the "Switch User" functionality which allows a clerk to switch from one secure Web account to another without logging out of one secure account and logging back into another.

- The client must be eligible for the waiver services on the date(s) of service being billed.

- The services must be on the client's care plan in the form of a Prior Authorization (PA), if on the Waiver Crosswalk, and the PA must be in an approved status.

- If EVV mandated services, service check-in/out must be confirmed in the Santrax system. Please refer to the At Your Fingertip Tip #16 - Alternate Claim Solution Explanation of Benefits Codes located on the www.ctdssmap.com Web site. Select Electronic Visit Verification > At Your Fingertips Tip Sheets > Alternate Claim Solution for information to ensure a confirmed visit in Santrax is attached to a Prior Authorization.

- The procedure code must be payable for the date(s) of service billed.

Providers are encouraged to review training presentations for the Waiver(s) for which they have enrolled on the www.ctdssmap.com Web site via the Provider Training Link. Providers are also encouraged to review tip sheets and training videos under the Electronic Visit Verification Menu when unable to view client and PA information for service confirmation in EVV.

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Attention: Waiver Providers

Renewal of Acquired Brain Injury (ABI) Waivers

The State of Connecticut Department of Social Services (DSS) has renewed the Home and Community Based Services (HCBS) Acquired Brain Injury Waivers. These renewals have resulted in the following procedure code changes effective December 1, 2019:

1564P, Specialized Medical Equipment, has been end dated effective November 30, 2019 and no longer payable for dates of service December 1, 2019 and forward, for both ABI Fiduciary and Service providers.

1397Z, Assistive Technology, has been added to the ABI Fiduciary fee schedule, effective December 1, 2019. As a result, Allied Community Resources will be responsible for billing these services for providers, which require Prior Authorization (PA) from DSS for a maximum amount of $15,000 over a three-year period.

The ABI Procedure Code Crosswalk and Fee Schedule have been updated to reflect these changes.

The ABI Procedure Code Crosswalk is located on the www.ctdssmap.com Web site. From the Home page > Select Provider Training > Materials > ABI Service Provider Workshops > ABI Procedure Code Crosswalk.

The ABI Fee Schedule is located on the www.ctdssmap.com Web site. From the Home page > Select Provider > Provider Fee Schedule Download > I Accept > Acquired Brain Injury Fiduciary CSV or Acquired Brain Injury Service Provider CSV to view these changes and determine service reimbursement.

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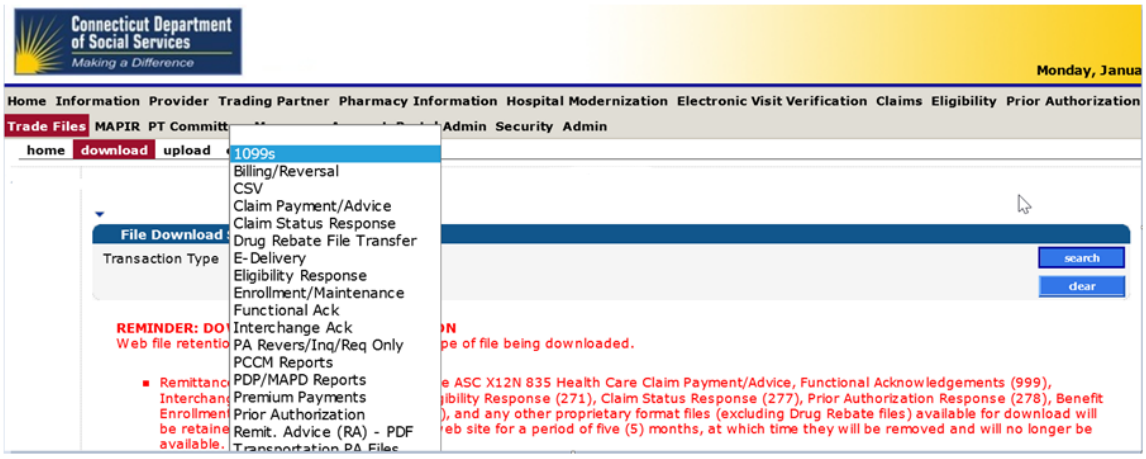
Attention: All Providers

1099s Are Now Available on the Connecticut Medical Assistance Program Web Site

The Department of Social Services (DSS) and DXC Technology are pleased to announce that providers are now able to download their 1099s from the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com. The 1099s for the 2019 tax year were posted on the providers' Secure Web Portal on January 29, 2020. The functionality to download the 1099s is available for all Master Users and any clerk accounts that have access to download PDF Remittance Advice files. The 2019 1099s were also mailed to providers on January 23, 2020.

Providers wishing to download their 2019 1099 from www.ctdssmap.com would do so by logging into their secure Web portal account, selecting Trade Files, then download. Providers must then click on the 1099s selection located at the top of the drop-down menu.



Users would then scroll down and select the 2019 1099 from the "Current Files Available for Download" panel. As a courtesy, the 2018 1099s were also loaded to providers' secure Web portal accounts in the middle of February 2020 for historical reference.

The retention period for 1099s on the secure Web portal account will be three (3) years. Providers are encouraged to download and save a local copy of the 1099s as after three (3) years, the downloadable files will be removed and no longer available.

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Attention: All Providers

Your Free Training Resources

Did you know that DSS offers a variety of ***free*** training resources for their providers? In addition to the New Provider Workshop, DSS also offers refresher trainings, provider manuals, provider bulletins, Important Messages and a number of other publications that can assist in successfully navigating the Connecticut Medical Assistance Program (CMAP).

New Provider Workshop: The goal of the New Provider Workshop is to provide a basic understanding of the Connecticut Medical Assistance Program (CMAP). The training is offered four (4) times per year and is designed to address questions and concerns that new office staff and newly enrolled providers may have regarding their use of the www.ctdssmap.com Web site. Among the topics covered at each training workshop are client eligibility, claim processing, web claim inquiry and resources that can be found on the CMAP Web site. Workshop attendees learn how to research a client's eligibility and understand the data returned, how to verify that a client has an approved prior authorization (PA) and how to read the remittance advice (RA).

Yearly Refresher Workshops: The goal of the yearly refresher workshops is to update providers on new information specific to their programs and/or provider type. Among the topics covered at each training workshop are new program rules, added service codes, proc/mod lists and their uses, how to verify client eligibility, perform web claim inquiries and resources that can assist in successful claims submittal. These workshops can be used to train new staff and as a refresher for current staff in using the www.ctdssmap.com Web site and secure Web site features. Invitations to upcoming workshops can be found on the www.ctdssmap.com Web site. Providers are encouraged to register for their preferred workshop(s) to secure a seat in the training room/environment early as seating can be limited.

To access the invitations and previous New Provider and Yearly Refresher workshops, navigate to www.ctdssmap.com and select Provider Training from the Provider Quick links box on the left side of the home page.

Important Messages: Important Messages contain urgent messages that require immediate communication to the provider community as well as links to important information regarding recent/upcoming system changes. If you have enrolled in e-messaging, a link to the Important Messages are sent to your email address. If you have not enrolled in e-messaging, you can review the most recent Important Messages on the home page of the CMAP Web site by scrolling down on the Home Page to the Important Messages subheading.

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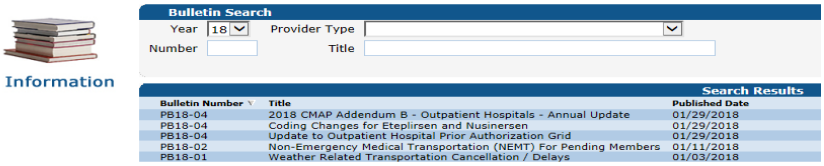
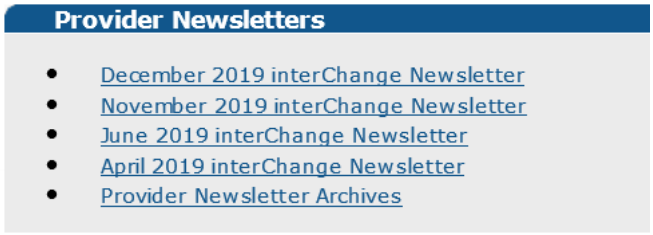
Provider Bulletins: Provider Bulletins are publications posted to relevant provider types/ specialties documenting changes or updates to CMAP. The online database of bulletins goes back to the year 2000 so that providers can research historical changes for their provider type. The bulletin search allows you to search for specific bulletins by year, number, or title. The provider bulletins can be found by navigating to Information > Publications on the CMAP Web site.



Provider Newsletters: Provider Newsletters are quarterly publications that cover a wide range of topics. Previous newsletter articles include Hospital Transfers, Pharmacy Web Prior Authorization Tool, and Expansion of Services for Acquired Brain Injury service providers.

The provider newsletters can be found by navigating to Information > Publications and scrolling down to Provider Newsletters on the CMAP Web site.



The Training Page: The training page contains links to the Acquired Brain Injury, Autism, Connecticut Home Care and Personal Care Assistant Waiver crosswalks and the most recent yearly refresher workshops. These documents are beneficial to new staff and as a refresher for existing staff to review programmatic updates to their provider type.

Provider Manuals: The provider manuals offer specific information regarding CMAP and can be used to answer most questions regarding the program. Chapters 1-6 and 9-12 contain program information applicable to all provider types while Chapters 7 and 8 are provider type specific. Each chapter should be used in conjunction with any provider bulletins and Important Messages. The provider manuals can be found by navigating to www.ctdssmap.com and selecting Information> Publications> Provider Manuals.

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Attention: All Providers

How to Register for E-mail Subscriptions

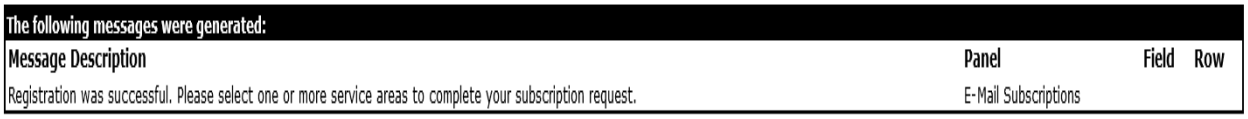
Providers must register to receive provider bulletins and policy transmittals, workshop invitations and program updates and reminders electronically via the email subscription function on the Connecticut Medical Assistance Program (CMAP) www.ctdssmap.com Web site. There are many benefits to the electronic delivery of communication, including:

- faster distribution of information to the provider community
- any office personnel can subscribe to receive program information via e-mail
- a simplified subscription process that can be completed very quickly allowing information to get into the right hands

To Subscribe:

1. Access the www.ctdssmap.com Web site.
2. Select Provider > E-mail Subscription from the drop-down menu.
3. Once on the E-mail Subscription page, enter the e-mail address you wish to subscribe.
4. Re-enter the e-mail address for verification.
5. From the right-hand side of the page, use the checkboxes to select the available subscriptions you would like to receive.
6. Once complete, select Save.

Once you have successfully registered an email address, you will see the following message:



The following messages were generated:

Message Description	Panel	Field	Row
Registration was successful. Please select one or more service areas to complete your subscription request.	E-Mail Subscriptions		

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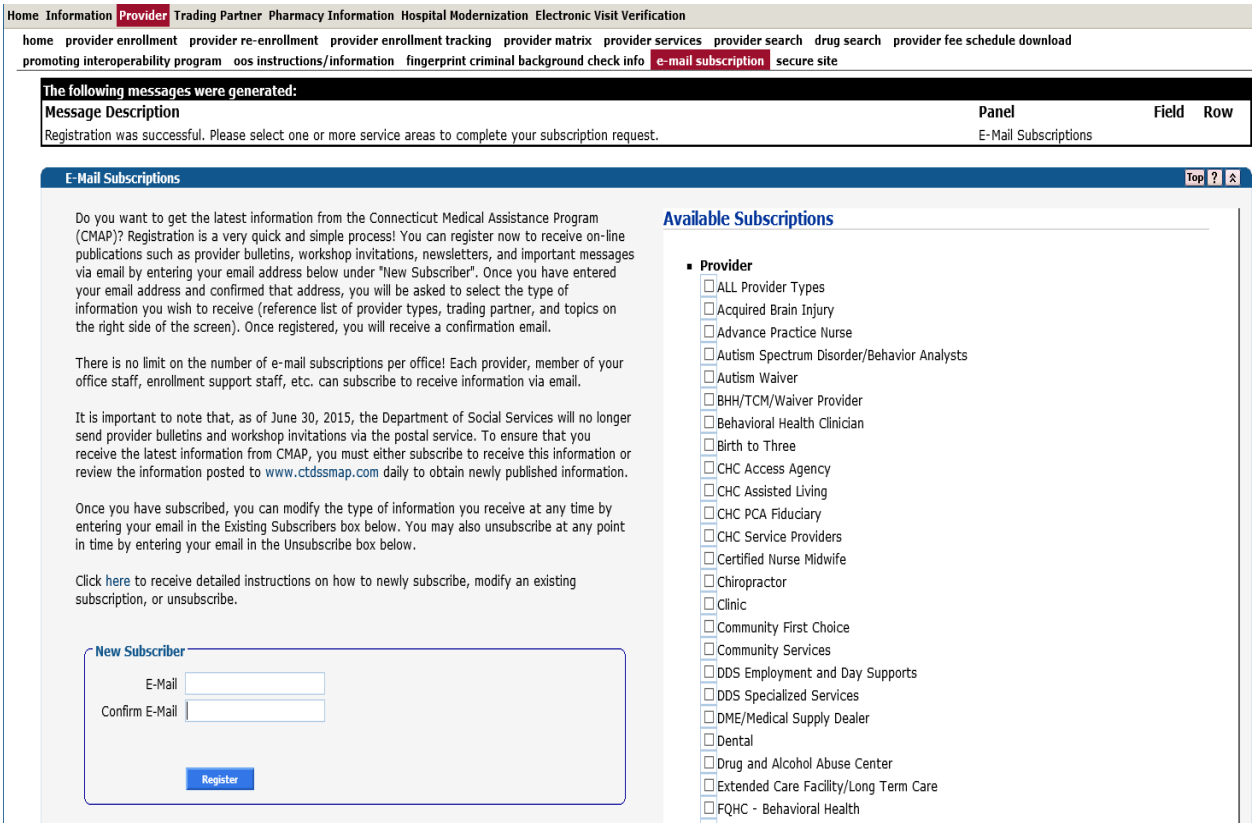

Once you have successfully enrolled, you will receive a confirmation notice that includes the provider type(s) and/or topic(s) you selected from the checkboxes.

Please note that, if you are already subscribed, you will receive a message that states “The e-mail address already exists”. If you receive this message, you may proceed to modify your existing subscription.

To Modify an Existing Subscription:

Once you have subscribed, you may modify your subscriptions at any time by performing the following steps:

1. Access the www.ctdssmap.com Web site.
2. Select Provider > E-mail Subscription from the drop-down menu.
3. Once on the E-mail Subscription page, enter the e-mail address you wish to modify in the Existing Subscribers section of the panel.
4. From the right-hand side of the page, use the checkboxes to modify your subscriptions.
5. Once complete, select Save.

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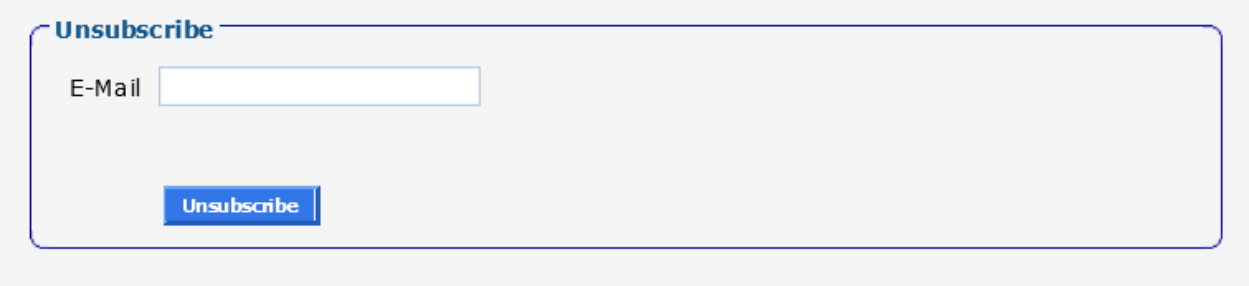
Once you have successfully modified your subscriptions, you will receive a confirmation notice that includes the provider type(s) and/or topic(s) you selected from the checkboxes.

If you change your e-mail address, you must **Unsubscribe** the incorrect email by doing the following:

1. Access the www.ctdssmap.com Web site.
2. Select Provider > E-mail Subscription from the drop-down menu.
3. Once on the E-mail Subscription page, enter the e-mail address you wish to unsubscribe in the Unsubscribe section of the panel.
4. Once complete, select Save.



Once the email has been unsubscribed you will see the following message:

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Attention: Waiver Providers

Common Explanation of Benefits (EOB) And How to Resolve Them for Waiver Providers

When a claim processes through the Connecticut Medical Assistance Program (CMAP), it is subject to a series of systematic edits and audits that check the validity of the claim data. If the claim data is not able to be validated, the claim will deny payment and an explanation of benefit (EOB) code will be posted to the claim that will help explain why the claim did not pay.

ALL CLAIMS ARE EDITED AND VALIDATED TO ensure such things as:

- The submitted provider is actively enrolled on the date of service.
- The client is eligible on date of service.
- The procedure code submitted is valid for the provider type and is not a duplicate of an already paid claim.
- The billed procedure code has a prior authorization (PA) in a care plan for the services provided.

When a claim is denied payment, the issue that prevented payment must be corrected, if possible, prior to claim resubmittal or the claim will again deny payment.

Common EOB's

EOB Code 2003 - Client Ineligible for dates of service
Cause: This EOB code will set when the client is not eligible on their appropriate waiver at the time of service.
Resolution: The client eligibility file will need to be updated with a mandated waiver benefit plan or a change made to the effective dates of eligibility prior to resubmittal of the claim(s).

For assistance with the client's waiver benefit plan, providers can contact the Community Options Unit at DSS via an encrypted email at Waiver.DSS@ct.gov. For clients with the Mental Health (MH), waiver please contact Advanced Behavioral Health (ABH) at (860) 704-6201.

EOB Code 4021 - Procedure Billed is not a Covered Service under the Client's Benefit Plan.
Cause: If EOB code 4021 is the only EOB that sets on the claim, the client does not have a mandated waiver in their benefit plan.
Resolution: If any other EOBs are on the claim, take action on the *other* EOB codes and disregard EOB code 4021. If EOB 4021 is the only EOB that sets on the claim, please contact the Community Options Unit at DSS via an encrypted email at

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Waiver.DSS@ct.gov for assistance with clients waiver benefit plan. For clients with the MH waiver, please contact ABH at (860) 704-6201.

EOB Code 3015 – Care Plan Required
Cause: The claim is for a client enrolled in Connecticut Home Care (CHC), Acquired Brain Injury (ABI), Autism (AUT), Personal. Care Assistance (PCA), and MH waiver benefit plan and a care plan has not yet been established for this client.
Resolution: The service is not payable unless the agency responsible for the clients care plan cre-ates a care plan and adds the service being pro-vided to the care plan. If the client has CHC, PCA, AUT, or ABI waiver, the provider should contact the Access Agency responsible for the clients care for assistance and request that a care plan be up-loaded to the DSS Web portal, www.ctdssmap.com. If the client has MH waiver, the provider should contact ABH for assistance and request that a care plan be uploaded to the DSS Web portal, www.ctdssmap.com.

EOB Code 3016 - Service not Covered under Care Plan
Cause: This EOB code will set when a care plan is present on the DSS Web portal but there is not a Prior Authorization (PA) on the care plan for the services being provided.
Resolution: If the client has CHC, PCA, AUT, or ABI waiver, the provider should contact the Access Agency responsible for the clients care for assistance and request that a PA be uploaded to the DSS Web portal, www.ctdssmap.com.
If the client has MH waiver, the provider should contact ABH for assistance and request that a PA be uploaded to the DSS Web portal, www.ctdssmap.com.

EOB Code 3003 - Prior Authorization is required for payment of the service (units for the service are exhausted)
Cause: This EOB code will set when the units on an existing PA are exhausted.
Resolution: To remedy this EOB, a one-time only PA will have to be uploaded to the DSS care plan or additional units must be added to the frequency of the existing PA. If the client has CHC, PCA, AUT, or ABI waiver, the provider should contact the Access Agency responsible for the clients care for assistance and request that a one-time only PA be uploaded to the DSS Web portal, www.ctdssmap.com. If the client has MH waiver, the provider should contact ABH for assistance and request that a one-time only PA be uploaded to the DSS Web portal, www.ctdssmap.com.

EOB Code 5151 - Units exceed frequency units on care plan.
Cause: This EOB code will set when the units exported for claims processing exceed the remaining units related to the frequency on the PA.
Resolution: Additional units must be added to the frequency of an existing PA by the Access/ Case Management Agency for a resubmitted claim to be paid.

EOB Code 8236 - Claim was Recouped due to PA Change
Cause: This EOB code will set when a claim is voided due to a PA change.
Resolution: A new claim is systematically created when claims are reprocessed due to a PA change by an Access or Case Management Agency. The claims that were billed against the original PA will be systematically reprocessed to sync them to the new PA. This EOB code will be attached to an Internal Control Number (ICN) that starts with region code 52.

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EOB Code 8237 – Claim Systematically Reprocessed Due to Retro Change-Information Only
Cause: This EOB will set when a claim is systematically created due to a PA change by an Access or Case Management Agency.
Resolution: The claims that were billed against the original PA were voided and a new claim will be systematically created to sync the services performed to the new PA. This EOB code will be attached to an Internal Control Number (ICN) that starts with region code 24. This claim will not appear on the PDF RA because there was no financial impact due to the recoup and reprocess of the claim, however, the affected claim will be displayed on the DSS Web portal and on the ASC X12N 835.

EOB Code 8238 – Claim Systematically Reprocessed Due to a PA/Service Order Charge
Cause: This EOB will set when a claim is systematically created due to a PA change by an Access or Case Management Agency.
Resolution: The claims that were billed against the original PA will be voided and a new claim will be systematically created to bill services performed against the new PA. This EOB code will be attached to an Internal Control Number (ICN) that starts with region code 24.

If you have additional questions regarding claims that have denied payment, there are additional resources that can assist you. On the DSS Web site, you can access Provider Manual Chapter 12 – Claim Resolution Guide by navigating to www.ctdssmap.com -> Information > Publications then scroll down to the Provider Manuals section and select Chapter 12. Chapter 12 has some of the most common EOB reason codes for all provider types and how to resolve them.

If after researching the EOB code you require additional assistance in resolving the claim denial, please contact the Provider Assistance Center at 1-800-842-8440.

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Attention: All Providers

Connecticut Medical Assistance Program COVID-19 Response

In response to the declaration of a public health emergency as the result of COVID-19 (coronavirus) in Connecticut, the Department of Social Services (DSS) has implemented several policy changes published across a number of different provider bulletins which can be accessed via an Important Message (IM) titled "COVID-19 Information and FAQs" located on the home page of the www.ctdssmap.com Web site. The IM will serve as a central repository for all COVID-19 changes and provider notifications.

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Appendix

Holiday Schedule

Date	Holiday	DXC Technology	CT Department of Social Services
5/25/2020	Memorial Day	Closed	Closed
7/3/2020	Independence Day (Friday preceding)	Closed	Closed
9/7/2020	Labor Day	Closed	Closed
10/12/2020	Columbus Day	Open	Closed
11/11/2020	Veterans Day, observed	Open	Closed
11/26/2020	Thanksgiving Day	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.

PB20-39 CMAP COVID-19 Response—Bulletin 25: Non-Emergency Medical Transportation and Non-Emergency Ambulance Transportation

PB20-35 CMAP COVID-19 Response—Bulletin 20: TU Modifier—Overtime

PB20-33 CMAP COVID-19 Response—Bulletin 23: Changes To the Prior Authorization Requirements for Specified Services

PB20-32 CMAP COVID-19 Response—Bulletin 18: Temporary Changes to Signature Requirement for Prescription Medications

PB20-30 CMAP COVID-19 Response—Bulletin 17: Temporary Changes to Claim Submission for Coagulation Factor Drugs

PB20-29 CMAP COVID-19 Response—Bulletin 16: Emergency Durable Medical Equipment Changes Pertaining to Customized Wheelchairs

PB20-28 CMAP COVID-19 Response—Bulletin 13: Emergency Temporary Telemedicine Coverage/ Telephonic Coverage for Specified Home Health And Hospice Services

PB20-27 CMAP COVID-19 Response—Bulletin 12: Waiver Of Certain Requirements and Temporary Procedural Changes for Home and Community-Based Waiver Programs

PB20-26 CMAP COVID-19 Response—Bulletin 11: Emergency School Based Child Health (SBCH) Program Changes

PB20-25 CMAP COVID-19 Response—Bulletin 10: Expanded Use of Synchronized Telemedicine for Specified Behavioral Health Group Therapy Services and Autism Spectrum Disorder Services

PB20-24 CMAP COVID-19 Response—Bulletin 9: Emergency Temporary Telemedicine Coverage for Specified Therapy Services Rendered at Rehabilitation Clinics

PB20-23 CMAP COVID-19 Response—Bulletin 8: Emergency Temporary Telemedicine Coverage for Physical Therapy, Occupational Therapy & Speech Therapy Services

PB20-22 Clarifying Guidance of MEDS Policy Pertaining to Procedure Codes K0553 and K0554 for Therapeutic Continuous Glucose Monitors (CGM)

PB20-20 New Prior Authorization Submission Guidelines For PAs That Require a Letter of Medical Necessity

PB20-19 CMAP COVID-19 Response—Bulletin 7: Enhanced Care Clinic (ECC) Access Requirements

PB20-18 CMAP COVID-19 Response—Bulletin 15: Emergency MEDS Program Changes

PB20-17 CMAP COVID-19 Response—Bulletin 6: Emergency Remote Early Intervention Services

PB20-16 Remote Early Intervention Treatment Services

PB20-15 CMAP COVID-19 Response—Bulletin 5: Elimination Of Copayments for Services Rendered to HUSKY B Members

PB20-14 CMAP COVID-19 Response—Bulletin 4: Expanded Telemedicine and New Audio-Only (Telephonic) Services

PB20-13 CMAP COVID-19 Response—Bulletin 3: Emergency Pharmacy Program Changes

PB20-12 CMAP COVID-19 Response—Bulletin 2: Laboratory Testing Coverage

PB20-11 Accessing the Provider's Re-enrollment Due Date

PB20-10 CMAP COVID-19 Response—Bulletin 1: Emergency Temporary Telemedicine Coverage

PB20-09 New Coverage of Specified Telemedicine Services Under the Connecticut Medical Assistance Program (CMAP)

PB20-08 Performing Providers Required for Autism Special Groups

PB20-07 Out-of-State and Border Hospital Reimbursement-Effective January 1, 2020

PB20-06 Adding Ocrelizumab to the Physician Office & Outpatient Fee Schedule

PB20-05 Increasing the Reimbursement Rates for Select Long-Acting Reversible Contraceptive Devices

PB20-04 2020 update to MEDS Fee Schedule 1) HIPAA Complaint Codes and 2) Revised Payment Methodology for Repairs to Codes on MEDS Fee Schedules

PB20-03 Addition of Codes K0553 and K0554 for Therapeutic Continuous Glucose Monitors (CGM) - MEDS Fee Schedule Update
Administered Drugs
Therapy

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

CTDSSMAP-ProviderEmail@dxc.com

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