March 2024
Connecticut Medical Assistance Program
https://www.ctdssmap.com

The Connecticut Medical Assistance Program

# Provider Quarterly Newsletter

## New in This Newsletter


- **Home Health Providers:**
  Home Health Providers—EVV
- **Pharmacy Providers:**
  How to Correctly Bill Pharmacy Claims for Dual Eligible Beneficiaries and Individuals with Third Party Insurance
- **Inpatient Hospitals:**
  Reminders/Upcoming Changes for Inpatient Hospitals

# Table of Contents

**All Providers/Trading Partners:**
The Vital Role of Address Verification in Your Secure Web Portal....Page 1

**Home Health Providers:**
Home Health Providers—EVV....Page 2

**Inpatient Hospital Providers:**
Reminders/Upcoming Changes for Inpatient Hospitals....Page 3

**Medicaid/Medicare Providers:**
Submitting Medicare Advantage Plan Crossover Claims to CT Medicaid.... Page 4

**Hospital and Long Term Care Providers:**
How to Submit Claims after Medicare Made Payment/Denial.... Page 4

**Pharmacy Providers:**
How to Correctly Bill Pharmacy Claims for Dual Eligible Beneficiaries and Individuals with Third Party Insurance.... Page 5

**All Providers:**
Update Any Ownership Changes with DSS/Gainwell Technologies Today!....Page 6

**Appendix**
Holiday Schedule.... Page 8
Provider Bulletins.... Page 9

# Attention: All Providers/Trading Partners

## The Vital Role of Address Verification in Your Secure Web Portal

The Medicaid system, designed to support those in need of comprehensive healthcare services, relies heavily on accurate provider information for efficient operations. Neglecting this essential review of information may lead to a cascade of issues, including:

- Claim denials
- Misdirected payments
- Loss of provider eligibility
- Recoupment of previously paid claims

**This essential review should include:**

- Trading Partner Name/Address - If the Trading Partner Name/Address has changed since the original Trading Partner Agreement was established, please update this field.
- Updates to contact names, telephone numbers and e-mail addresses for the Secure Web Account.
- Review of all Clerk Accounts with deletion of non-current employee accounts to ensure only authorized users have access to Protected Health Information.
- The update of communication data (telephone number and e-mail address) allows efficient support/outreach to Trading Partners and Providers by EDI Support and Provider Services when problems with file submissions are detected.

**To verify addresses in your secure web portal account, the main account administrator must:**

Click on "Account," "*Demographic Maintenance,*" and then "*Location Name Address*"

**Please carefully review the instructions in Chapter 10 of the provider manual regarding address updates so as not to negatively impact claims payment if an address is a Person-Centered Medical Home (PCMH) site.**

Back to Table of Contents

## Home Health Providers—EVV

All home health providers should now be utilizing EVV to capture HHCS visit data in accordance with the federal mandate in the 21st Century Cures Act. As a result, providers will begin to receive the following Explanation of Benefits (EOB) codes on claims **effective April 1, 2024, and forward**:

For Non-Waiver Home Health Claims:

- Claims without a confirmed visit will result in a payment denial with EOB 3331 (i.e., Confirmed Visit Not Found) for **dates of service** effective **April 1, 2024, and forward**.
- Claims with confirmed visit units that are exceeded will set EOB 3332 (i.e., Confirmed Visit Units are Exceeded) for **dates of service** effective **April 1, 2024, and forward**.

For Waiver Home Health Claims:

- Claims without a confirmed visit will result in a payment denial with EOB 3327 (i.e., Confirmed Visit Not Found) for **dates of service** effective **April 1, 2024, and forward**.
- Claims with confirmed visit units that are exceeded will set EOB 3328 (i.e., Confirmed Visit Units are Exceeded) for **dates of service** effective **April 1, 2024, and forward**.

**EOB 3328 and EOB 3332 Confirmed Visit Units are Exhausted**

**Cause**

A claim containing an EVV mandated service contains the same client ID, provider ID, date of service, service code and modifier(s) as the confirmed visit, however, the visit units have been exhausted due to a previously paid claim. There are no more units on the confirmed visit to pay the denied units.

**Resolution**

The units on the confirmed visit in Santrax must be increased prior to claim resubmittal.

**EOB 3327 and EOB 3331 Confirmed Visit Not Found**

**Cause**

The claim contains an EVV mandated service for which there is no matching confirmed visit in the Santrax system that contains the same client ID, provider ID, date of service, service code and modifier(s).

**Resolution**

Provider must verify that the visit that they are

Continued on Next Page

Back to Table of Contents

Continued from Previous Page

trying to bill is in a confirmed status in the Santrax system prior to rebilling. It may take up to 24 hours for a confirmed visit to be communicated to Gainwell Technologies, so the visit may not be able to be billed immediately following visit confirmation. Provider should also ensure that the claim details match the confirmed visit's details, or this EOB may set again.

**Cause**

If a claim has a modifier that is not present on the confirmed visit or lacks a modifier that is present on the confirmed visit, the claim will deny payment.

**Resolution**

Provider should ensure that the claim being exported for adjudication matches the confirmed visit in Santrax. Provider should make sure the visit has the same client ID, provider ID, date of service, service code and modifier(s) as the claim.

# Attention: Inpatient Hospital Providers

## Reminders/Upcoming Changes for Inpatient Hospitals

Inpatient Hospital Claims require a Prior Authorization (PA).

Make sure that when you receive two separate per-diem (Rehab or Behavioral Health) PAs, that the PA date ranges do not overlap – when this happens, the claim ONLY picks up one of the PAs. A denial will be received for the dates on the second PA.

Back to Table of Contents

## Attention: Medicare/Medicaid 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, the claim adjustment reason code (CARC) of 3 for co-payment should not be used. 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. 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.

## Attention: Hospital and Long Term Care Providers

### How to Submit Claims After Medicare Made Payment/Denial

If Medicare coverage exists, the claim must first be submitted to Medicare for reimbursement of services. If Medicare made payment or allowed the claim, the claim should be automatically transmitted to Gainwell Technologies by Medicare. This should occur within 45 days of the provider's receipt of the Medicare Explanation of Medicare Benefit (EOMB). This claim is called a crossover claim. If this automatic transmission does not occur, the provider should submit the crossover claim to Gainwell Technologies. If a provider's crossover claims are not routinely submitted automatically to Gainwell Technologies by Medicare, the provider should contact Gainwell Technologies to determine the cause. If Medicare denied the claim, Medicare will not send the claim to Gainwell Technologies. The provider must submit this claim to Gainwell Technologies. This claim is no longer a crossover claim. A claim denied by Medicare is considered a straight Medicaid claim.

Back to Table of Contents

# Attention: Pharmacy Providers

## How to Correctly Bill Pharmacy Claims for Dual Eligible Beneficiaries And Individuals with Third Party Insurance

Procedures for billing the co-insurance of medications/supplies to the Connecticut Medical Assistance Program (CMAP) will vary depending on the individual beneficiary's primary insurance plan. When a Medicare Advantage (MA) plan covers Part B drugs through its Medicare Part D Program, pharmacies must submit the co-pay portion of the claim, typically the 20% co-insurance, in the Professional Crossover claim format.

Pharmacies may use their vendor software to submit these claims as an 837P file or may submit them through the CMAP secure Web site at www.ctdssmap.com.

Comprehensive instructions for successful claim submission can be found in Provider Bulletin 2020-01, *Clarification of Billing Requirements for Medications and Supplies Covered by Medicare Part D and Medicare Part B Including Additional Third Party Insurance.*

As a reminder, Medicare providers and suppliers may not bill clients in the QMB benefit plan for Medicare deductibles, coinsurance, or co-pays. Instead, pharmacies must submit these costs to CMAP.

Back to Table of Contents

# Attention: All Providers

## Update Any Ownership Changes with DSS/Gainwell Technologies Today!

As part of our ongoing commitment to transparency, accuracy, and efficiency, we want to emphasize the critical importance of updating any ownership changes to date, not only with the Department of Labor but also with the Department of Social Services (DSS) and Gainwell Technologies.

Your provider profile serves as a key representation of your business or service, and ensuring its accuracy is important for various reasons. While many owners diligently update their information with the Department of Labor when an ownership change occurs, it is equally crucial to maintain accuracy within the DSS database. This approach is necessary for your business to maintain:

1. **Importance of Reporting to proper state entities:** The Department of Social Services/ Gainwell Technologies, and the Department of Labor play distinct roles in overseeing different aspects of your business. DSS and Gainwell focuses on social services, support services and claims processing. The Department of Labor concentrates on employment-related matters. Updating your information with both entities is required.
2. **Avoidance of Discrepancies:** Discrepancies between your profiles can lead to confusion and potential misunderstandings. Whether it's contact information, service details, or certifications, aligning all profiles mitigates the risk of conflicting information.
3. **Fulfillment of Other Requirements:** Many social service programs require providers to submit accurate information for compliance and reporting purposes. For example: most recently is the requirement of the **Behavioral Health Attestation.** By maintaining updated profiles with both DSS/Gainwell and the Department of Labor, you ensure that your data aligns with program requirements and facilitates smoother reporting processes. Accurate profiles enable efficient communication between your organization and government agencies. Timely notifications, updates, and communications from both the DSS and the Department of Labor are crucial for staying informed about regulatory changes, program updates, and other important announcements. There are circumstances where the owner of a company may have to sign or acknowledge. If that information is not up to date then risk of claim denials and enrollment issues can occur.

***If your group practice has been through an ownership change and you have not notified DSS/ Gainwell Technologies, your group practice will not be able to fully complete the Behavioral Health Attestation.**

Some changes (e.g., a change in ownership or establishment of a new site) require the provider to complete a new provider application or new provider agreement, which may require the issuance of a new NPI/non-medical provider identifier. Pro-

Back to Table of Contents

Continued on Next Page

Continued from Previous Page

viders can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465- 3203. In the instance of the issuance of a new non-medical provider identifier, it is important to note that the format of the provider number may vary from the previous number. In the instance of a merger, the provider must complete a new provider application or provider agreement, as indicated above. It is very important that a provider indicate, via a letter to Gainwell Technologies, which NPI/non-medical provider identifier will no longer be a valid billing provider.

**Failure to inform Gainwell Technologies of changes may result in the denial of claims, misdirected payments, the loss of provider eligibility, or the recoupment of previously paid claims. Entering the new information on a claim form or prior authorization request is not notification of change.**

Thank you for your commitment to excellence in social services. Together, we can create a more streamlined and effective network for the benefit of all.

Back to Table of Contents

# Appendix

## Holiday Schedule

| Date | Holiday | Gainwell Technologies | CT Department of Social Services |
|---|---|---|---|
| 3/29/2024 | Good Friday | Closed | Closed |
| 5/27/2024 | Memorial Day | Closed | Closed |
| 6/19/2024 | Junteenth Day | Open | Closed |
| 7/4/2024 | Independence Day | Closed | Closed |
| 9/2/2024 | Labor Day | Closed | Closed |
| 10/14/2024 | Columbus Day | Closed | Closed |

Back to Table of Contents

# 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.

- PB24-22 Open Vendor Electronics Visit Verification (EVV) Model Implementation for Personal Care Services (PCS)—Technical Specification and Town Hall Registration
- PB24-16 Implementation of Children's Mental Health Urgent Crisis Centers Services for Children 18 Years Old and Younger
- PB24-15 Open Vendor Electronic Visit Verification (EVV) Model Implementation for Personal Care Services (PCS)
- PB24-14 Addition of Modifier
- PB24-13 Claim Adjustment Reason Codes (CARC) Changes on the X12 835 Health Care Claim Payment/Advice
- PB24-11 Revised Deadline: Performing Providers Required for Behavioral Health Clinic Providers
- PB24-10 Reimbursement Change on Pharmacy Point of Sale (POS) Claims submitted for Blood Glucose Test Strips and Alcohol Prep Pads
- PB24-09 Place of Service (POS) Requirements for Substance Use Disorder (SUD) Treatment
- PB24-08 Clarifying Billing Guidance for Periodontal Services
- PB24-07 Addendum to the Provider Enrollment Agreement for Nursing Facilities
- PB24-06 Payment Error Rate Measurement (PERM) Program Audit Requests
- PB24-05 1. Updates to the Reimbursement Rates of Select Manually Priced Procedure Codes 2. Updates to the Reimbursement Rates for Select Long-Acting Reversible Contraceptive Device
- PB24-04 2024 Revision of Rates for Certain Clinical Diagnostic Laboratory Testing Codes
- PB24-03 Connecticut Medical Assistance Program Provider Satisfaction Survey
- PB24-02 Mental Health Access Improvement Act
- PB24-01 UPDATE: Rate Increases to Delivered Meals and Adult Day Services
- PB23-88 Policy Updates and Changes to Clinical Review Criteria
- PB23-87 1. January 2024 Quarterly HIPAA Compliant Updates—Behavioral Health Clinic Fee Schedule 2. Updating Physician Administered Drugs on the Behavioral Health Clinic Fee Schedule
- PB23-86 Updating Physician Administered Drugs on the Dialysis and Family Planning Clinic Fee Schedules
- PB23-85 January 2024 HIPAA Compliant Updates for MEDS
- PB23-84 January 2024 Quarterly HIPAA Compliant Update—Laboratory Fee Schedule
- PB23-82 1. January 2024 Quarterly HIPAA Compliant Updates-Medical Clinic Fee Schedule 2. Updating Physician Administered Drugs on the Medical Clinic Fee Schedule
- PB23-81 Out-of-State and Border Hospital Reimbursement-Effective January 1, 2023
- PB23-80 Annual Update to the Inpatient Hospital Adjustment Factors and Update to the APR-DRG Weights
- PB23-79 January 2024 Quarterly HIPAA Compliant Updates-Dental Fee Schedules for Adult and Children
- PB23-78 Obstetrics Pay for Performance Extended
- PB23-77 January 2024 Quarterly HIPAA Compliant Update—Clinic—Ambulatory Surgical Center Fee Schedule
- PB23-76 1) January 1, 2024 Changes to the Connecticut Medicaid Preferred Drug List (PDL) 2) Reminder About the 5-day Emergency Supply 3) Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL) 4) Pharmacy Web PA Tool
- PB23-75 Updating the Reimbursement Rates for Nursing Services For Home Health Adult Complex/High Tech Level of Care
- PB23-74 January 2024 HIPAA Compliant Update to the Independent Audiology and Speech and Language Pathology Fee Schedule
- PB23-73 January 2024 HIPAA Compliant Update to Rehabilitation Clinic Fee Schedule
- PB23-71 1. January 2024 Quarterly HIPAA Compliant Updates-Physician-Office and outpatient, and Physician Surgery Fee Schedules, 2. Physician Administered Drug Reimbursement Updates, 3. Increase to the Reimbursement Rate for ParaGard
- PB23-70 January 2024 Independent Radiology and Physician-Radiology Fee Schedules—Quarterly HIPAA Compliant Update
- PB23-69 Addition of Periodontal Benefits
- PB23-68 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program:
- PB23-67 Prior Authorization Threshold for Procedure Code B9998—NOC Enteral Supplies
- PB23-66 Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients

**Gainwell Technologies**

**PO Box 2991**

**Hartford, CT 06104**

**www.ctdssmap.com**

Back to Table of Contents