November 2019
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

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Attention: DME Providers

New Durable Medical Equipment (DME) Claim Edits

The Department of Social Services (DSS) has implemented new claim edits to validate the ordering, referring and rendering provider type/specialty listed on Durable Medical Equipment (DME) claims.

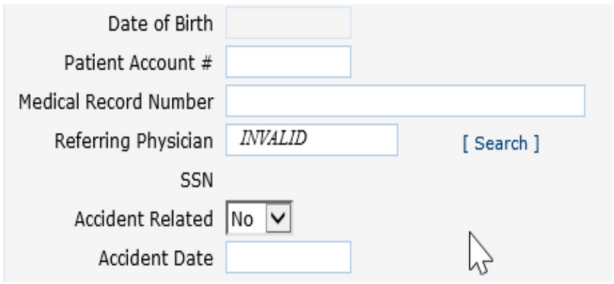
The following Explanation of Benefit (EOB) codes began to post to claims submitted with dates of service on or after 8/1/2019:

- **EOB 0562**: Referring provider type/specialty not valid for billing provider
- **EOB 0563**: Ordering provider type/specialty not valid for billing provider
- **EOB 0564**: Rendering provider type/specialty not valid for billing provider

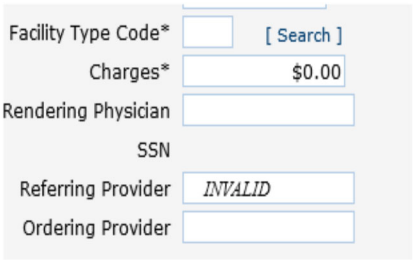
Due to the number of inquiries received regarding the new edits, DXC Technology has decided to publish a quick resolution guide to assist providers in correcting the denials.

EOB 0562: This EOB will post when the National Provider Identifier (NPI) of the referring provider in the header or detail of the claim is not valid for DME claims. Examples of invalid providers include organizations such as hospitals or clinics, opticians, psychologists, etc.
The denial refers to information listed under Web claim submission in one the following referring provider fields as shown below:

Claim Header

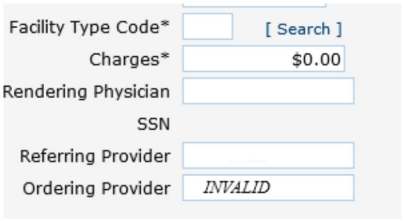


Claim Detail



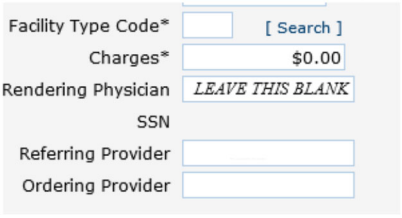
EOB 0563: This EOB will post when the NPI of the ordering provider on the claim detail is not valid for DME claims. Examples of invalid providers include organizations such as hospitals or clinics, opticians, psychologists, etc. The denial refers to information listed in the ordering provider field as shown below:

Claim Detail



EOB 0564: This EOB will post when the NPI of the rendering provider is not a DME provider. DME providers should leave this field blank as it is not required on DME claims or should enter their billing NPI in the rendering field. The denial refers to information listed in the rendering physician field as shown below:

Claim Detail



Chapter 12 of the Provider Manual will be updated to further assist DME providers in resolving the denials due to the new ordering/referring/rendering edits.

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Attention: All Providers

Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule

The Department of Social Services (DSS) and DXC Technology publish the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and the 835 schedule for the benefit of the provider community on the www.ctdssmap.com Web site. From the home page, click on the Provider Services link under the Provider box on the left-hand side of the page. Under the heading "Schedules", you can click on the current cycle/claim submission schedule to view claim submission and cycle dates.

Claims that are submitted electronically must be received by DXC Technology prior to 7:00 PM the day preceding the claims cycle date in order to be processed in that cycle. We encourage you to submit your claims as soon as possible and to not wait until the last day before the claims cycle.

As a reminder, Web RAs and 835s **will be available to download from the Web site by close of business day on the date posted.**

Attention: All Providers

Connecticut Medical Assistance Program (CMAP) Provider User Administration for Health Insurance Portability and Accountability Act (HIPAA) Compliance

The use of the World Wide Web has revolutionized healthcare in so many ways. Our CMAP Providers and Trading Partners provide the first line of defense in securing client Protected Health Information (PHI) and maintaining HIPAA compliance. CMAP recommends the following security tips to prevent breaches and to combat fraud, waste, and abuse.

- Routinely review and monitor CMAP Portal user roles (administrator and delegates) and levels of access.
- Timely CMAP Portal deactivation and removal of staff access that have separated employment.
- Report ALL suspected PHI breaches and related incidents immediately.
- Develop and maintain internal systematic training for staff regarding CMAP Portal registration privileges and **HIPAA** compliance.

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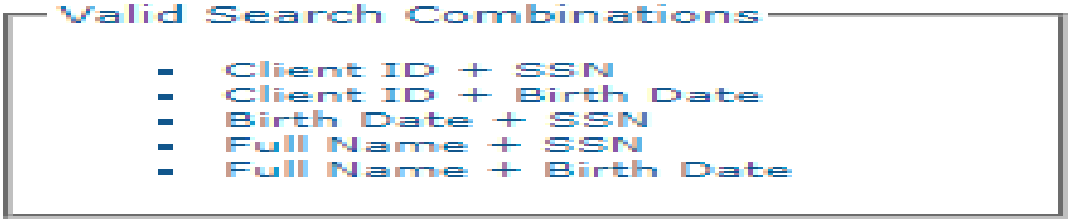
Attention: All Providers

Are You Checking Eligibility?

Providers are reminded that they should check eligibility often. Even if you have been given a prior authorization (PA) or referral from an access or case management agency, the client could have a change in circumstance that results in them losing their eligibility. Providers are reminded that they should check eligibility on the date of service, prior to performing said service and at regular intervals, to ensure that the client is eligible to receive the services to be provided.

To check eligibility on the Connecticut Medical Assistance Program (CMAP) Web site, follow these steps:

1. Access the Web site at www.ctdssmap.com and select Provider > Secure Site.
2. Login to the secure site using your username and password.
3. Select Eligibility.
4. Enter enough data to satisfy one (1) of the search criteria listed below. You will see additional fields to further refine your search, if applicable. Select Search.



Note: The From Date of Service (From DOS) and To Date of Service (To DOS) fields auto populate the current date. To verify eligibility for a previous date of service within a year from the current date, the provider will enter, in a MMDDCCYY format, the applicable dates in the From DOS and To DOS fields. The From DOS and To DOS cannot span a calendar month, be for a future date of service, or be over a year from the current date of service.

5. In the data that is returned, verify that the client has the appropriate coverage for the services you will be

	Benefit Plan			
Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
Husky D. For Behavioral Health Services, call BHP at 877-552-8247.	02/01/2018	02/21/2018	02/21/2018	

For more detailed instructions on searching and reviewing eligibility, please see chapter 4 of the Provider Manuals – Eligibility. This chapter provides more information in researching eligibility using the CMAP Web site, Automated Voice Response System (AVRS), Point of Sale (POS) and the Provider Electronic Solutions (PES) software.

Providers verifying eligibility on the www.ctdssmap.com Web site can find additional information about the eligibility verification request responses that are received. To access this additional information, go to Information, then Publications, then scroll down to the second to last panel, "Claims Processing Information", and click on the Eligibility Response Quick Reference Guide link.
Please note: Only actively enrolled providers can perform an eligibility verification.

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Attention: ABI Service, CHC Service, PCA Service, Autism Service, Home Health Agencies and Access Agencies

Electronic Visit Verification (EVV) Who to Contact When you Have Questions

There has been some confusion about who providers should contact when they have questions about the Electronic Visit Verification (EVV) program. In many instances, providers can find answers to their questions on the Electronic Visit Verification Web page on the www.ctdssmap.com Web site. The following list will help you determine who to contact when you have questions:

Missing Clients or Prior Authorizations (PAs) – ABI, PCA, CHC Waivers and CT Home Program

Missing clients in the Santrax system may be the result of a client's eligibility not being added to the Department of Social Services' (DSS') eligibility file. Providers should first check client eligibility via their secure Web account. If eligibility is not on file, providers should send an email to Waiver.DSS@ct.gov and DSS will work to resolve the eligibility issues. If client eligibility has been verified and the client is still missing in the Santrax system, providers should then check to see if the client has an approved prior authorization (PA) on the CT Medical Assistance Program (CMAP) secure site. A client will only be present in Santrax if they are active on their EVV mandated waiver **and** have an approved PA on the CMAP secure site.

If you are missing PAs or there is a discrepancy in a PA from the service authorization given by the access/case management agency, confirm that the PA is on the CMAP secure site. If the PA does not exist, the Access Agency has not yet uploaded the PA to DXC Technology. Please contact the access agency responsible for the client's care plan for assistance in getting the PA uploaded. If the PA does exist on the CMAP secure site, it may take 2-3 days for the PA to appear in your Santrax system. Discrepancies between the PA on your secure Web account and the PA in the Santrax system should be communicated to the Provider Assistance Center at 1-800-842-8440 or via email at ctevv@dxc.com.

EVV system not working as expected – If your Santrax system is not functioning in the manner you expect, please contact Sandata at 1-855-399-8050 or by email at ctcustomercare@sandata.org and log a ticket.

Need an address or primary phone number change – If the client's address is not current, please contact the Access Agency and they will contact DSS to have the correction made. If the client's primary phone number is not current, please direct the client or the client's representative to contact the DSS Benefit Center at 1-855-626-6632.

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Attention: Mental Health Waiver (MHW) Program Performing Providers

Important Enrollment Reminder

Providers of Mental Health Waiver Services are reminded that they **must be actively enrolled** as a Mental Health Waiver Service Provider or Assisted Living Service Provider **to be reimbursed for services beginning on or after February 1, 2020**. Providers must enroll online via the Web portal on the www.ctdssmap.com Web site as a Mental Health Waiver (MHW) Service or Assisted Living Service Agency (ALSA) provider, based on the services they are credentialed to provide to MHW clients.

Providers who are not actively enrolled will not be reimbursed for the services they provide, nor can they continue to submit services to Advanced Behavioral Health (ABH), Fiscal Intermediary for the MH Waiver program, for reimbursement for dates of service on or after February 1, 2020. PLEASE NOTE: The application process may take several weeks to complete.

Both MHW and ALSA Service providers are required to submit a current credentialing letter from ABH to DXC Technology, Provider Enrollment Department, P.O. Box 5007, Hartford, CT 06102-5007. The Application Tracking Number (ATN), obtained at the end of the online enrollment process, must be noted in the upper right-hand corner of the document to ensure it is associated to the provider's enrollment application. This document must be received by DXC Technology in order for the enrollment application to be considered complete before it can be forwarded on to DSS' Quality Assurance Unit for further review and approval.

Providers enrolling as an ALSA provider must also have an updated DPH ALSA license on file. That license number will be required as part of the online enrollment process. However, a copy of the license is not required as part of the enrollment application process.

Successfully enrolled providers will receive both an Enrollment Approval and PIN letter to set up their Secure Web Account for the MHW program. The setup of a secure Web account allows the provider access to multiple online functionalities, to maintain an updated enrolled provider file in addition to multiple functionalities to support successful claim submission such as client eligibility verification, prior authorization (PA) inquiry and online claims submission and claim adjustment.

DXC Technology has offered both online enrollment and billing workshops for providers who have successfully completed the online enrollment process. Both the Enrollment and Billing workshop presentations can be accessed from the www.ctdssmap.com Web site Home page. From the Home page, click on the "Provider Training" link. Under the "Materials" heading, select the "MH Waiver Provider Workshops" link, then select the workshop presentation of your choice. The MHW Procedure Code Crosswalk can also be found by accessing the "MH Waiver Provider Workshops" link.

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Attention: Dental Providers

The Use of EXPAREL® (Procedure Code D9613) To Combat Opioid Over Use

Effective for dates of service January 1, 2019 and forward, the Department of Social Services (DSS) started reimbursing dental providers participating in the Connecticut Medical Assistance Program (CMAP) for the use of EXPAREL® (procedure code D9613) when used in conjunction with third-molar or full mouth extractions. Typically, dentists prescribe narcotics such as Percocet (oxycodone), Vicodin (hydrocodone) and codeine for post-surgery pain. However, breakthroughs in non-opioid medications are providing more effective ways to treat the post-surgical pain. EXPAREL® is an extended-release local anesthetic that blocks nerve impulses at the incision site. EXPAREL® is administered at the end of the surgery so that it will last for three, sometimes four days, when the pain is at its peak. After that, if a patient is still experiencing post-surgical discomfort, ibuprofen or other over-the-counter pain relievers can manage the pain.

By using EXPAREL®, dental providers can assist in addressing the current opioid epidemic plaguing the nation by reducing a client's exposure to opioids which is especially important for late teenagers and young adults. Please consult the dental fee schedule available on www.ctdssmap.com Web site for the reimbursement rate and prior authorization requirements for D9613.

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Appendix

Holiday Schedule

Date	Holiday	DXC Technology	CT Department of Social Services
11/11/2019	Veterans Day, observed	Open	Closed
11/28/2019	Thanksgiving Day	Closed	Closed
11/29/2019	Day after Thanksgiving	Closed	Open
12/25/2019	Christmas	Closed	Closed

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Appendix

Provider Bulletins

Below is a listing of Provider Bulletins that have recently been posted to www.ctdssmap.com. To see the complete messages, please visit the Web site. All Provider Bulletins can be found by going to the Information -> Publications tab.

PB19-72 New Policy Treatment of Varicose Veins of the Lower Extremity
PB19-71 New Coverage Guidelines for Zulresso (brexanolone)
PB19-69 Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients
PB19-68 Self-Measured Blood Pressure (SMBP) Monitoring Devices
PB19-67 New Prior Authorization Requirements for Short-Acting Opioid Medications
PB19-66 Update to the Dental Fee Schedule; Composite Resin Restoration of Incipient Carious Lesions
PB19-65 MEDS Fee Schedule Changes
PB19-64 Increase in Actual Acquisition Cost Percentage for Overhead Patient Lifts Codes (E0639 and E0640)
PB19-63 Electronic Delivery of Letters Update
PB19-62 Personal Care Assistant Waiver Provider Enrollment Opportunity
PB19-61 Rate Increases
PB19-60 Increasing the Reimbursement Rates for Select Long-Acting Reversible Contraceptive Devices (REVISED)
PB19-60 Updates to the Reimbursement Rates of Select Manually Priced Procedure Codes
PB19-59 Authorization for Palivizumab (Synagis®) 2019-2020 Respiratory Syncytial Virus (RSV) Season
PB19-58 Corneal Collagen Cross-linking: Coverage Guidelines and Prior Authorization Form—Corrected Procedure Codes
PB19-57 Hospice Rates for Federal Fiscal Year 2020
PB19-56 Change to Diagnosis Requirements for Durable Medical Equipment Claims
PB19-55 Newly Created Fee Schedule for Local Health Departments
PB19-54 Changes to PNMI Performing Provider Re-enrollment Process
PB19-53 Updates to Genetic Testing Prior Authorization Form
PB19-52 Obstetrics Pay for Performance
PB19-51 Update to the Dental Fee Schedule; Composite Resin Restoration of Incipient Carious Lesions
PB19-50 Claim Rejection E-Mailboxes for Providers and Who to Contact
PB19-49 Correction to the Guidance for Billing Evaluation And Assessment Services for Home Health Care Services
PB19-48 Adult Family Living Residency Requirements
PB19-47 Updated Prior Authorization Requirement for Frenulectomies for Children
PB19-46 Methadone Maintenance Reimbursement Rates
PB19-45 Elimination of Paper Trading Partner Agreements Notification
PB19-44 Revision of Rates for Certain Clinical Diagnostic Laboratory Testing Codes
PB19-43 Meals on Wheels Rate Increase
PB19-42 Update for the Adult Dental Fee Schedule Composite Restorations on Molar Teeth
PB19-41 Update to the Dental Fee Schedule Cone Beam Computer Tomography Imaging
PB19-40 New Coverage Guidelines: Peristeen Anal Irrigation System
PB19-39 Updated Guidance for Billing Medical Services Performed in Federally Qualified Health Centers
PB19-38 Update for Billing Coding for the Access for Baby Care to Dental Examination and Fluoride Program (ABC Program)
PB19-37 Clarifying the Guidance for Electronic Consultations Performed by Federally Qualified Health Centers
PB19-36 July 2019 Update to MEDS Fee Schedule
PB19-35 Private Non-Medical Institution (PNMI) Rates For Adult Mental Health Rehabilitation Services
PB19-34 Expedited Medicaid Eligibility Processing for Individuals with Medical Emergencies
PB19-33 Updating Tuberculosis Limited Benefit
PB19-32 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)
PB19-32 Reminder About the 5 day Emergency Supply
PB19-32 July 1, 2019 Changes to the Connecticut Medicaid Preferred Drug List (PDL)
PB19-31 Implementation of Electronic Delivery of Letters Update—Final Phase
PB19-30 Corneal Collagen Cross-linking: New Coverage Guidelines and Prior Authorization Form
PB19-29 Increase Per Diem Reimbursement Rates

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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