Connecticut Department of Social Services
Caring for Connecticut

Connecticut Medical Assistance Program
Department of Social Services & EDS
www.ctdssmap.com

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Connecticut interChange MMIS "Hot Topics":

- Real Time Claim Submission and Response Available Online!
- Charter Oak Health Plan
- Two New Managed Care Organizations
- Dental Carve Out Program for Connecticut Medical Assistance Program
- Prior Authorization Search on Provider Secure Web Site
- Provider Electronic Solution Reminder
- Clarification For Pharmacies on Other Insurance Coverage
- Provider Electronic Solution Reminder

Real Time Claim Submission and Response Available Online!

Dental, Professional and Institutional on-line claim submission is coming soon via the secure Provider Web Account Home Page. The response to your claim submissions will be received within seconds. Added features to the claim submission is the ability to:

- immediately adjust paid claims or,
- copy a claim and make changes to it and resubmit or,
- correct and resubmit denied claims (including crossover claims!) or,
- void paid claims

(article continued on page 2)

Charter Oak Health Plan

On August 1, 2008, EDS began processing pharmacy and behavioral health services claims for clients enrolled in the Charter Oak Health Plan. Governor Rell's new Charter Oak Health Plan offers affordable health coverage to adults who lack medical benefits, who have been uninsured for greater than six months, and do not qualify for a public program such as the HUSKY Plan, Medicaid or Medicare. Client applications became available on July 1, 2008. EDS is responsible for provider enrollment and claims processing for pharmacy and behavioral health services. All other covered services are coordinated by one of the following three health plans: Aetna Better Health, AmeriChoice by United Healthcare, or Community Health Network of Connecticut.

(article continued on page 4)

Two New Managed Care Organizations (MCO)

Effective August 1, 2008, the Department of Social Services (DSS) contracted with two new Managed Care Organizations (MCOs): Aetna Better Health, Inc. and AmeriChoice by United Healthcare. The Department also re-contracted with Community Health Network. HUSKY A, HUSKY B, and Charter Oak Health Plan clients are eligible to enroll in these MCOs. HUSKY clients who are currently members of BlueCare Family Plan or enrolled in Traditional Medicaid will be required to join a new MCO by the end of November.

(article continued on page 4)

In This Issue

Real Time Claim Submission and Response Available On-line!

(contined from page 1)
Providers are encouraged to review their business practices in order to maximize use of these on-line tools. Provider workshops will provide a hands on look of how this new tool will work for you.

In addition, the claim status inquiry via the secure Provider Web Account Home Page will allow you to view claims by logging onto the secure provider Web site using your provider logon ID and password. Once logged in, click "claims" and "claims inquiry". Should this option not be available to you, contact your primary account administrator for access to this functionality. Claims will be processed ***daily*** and providers can view electronically transmitted ***batch claims*** within 48 hours of transmission Paper claims will be available for on-line status inquiry based on mail and processing time. Electronically submitted claims require no handling or manual intervention. Visit our EDI page and see what options are available to you.

Claim Adjustment Reason Code List – Recent Updates

Providers use a list of codes to indicate if a payment was made by Other Insurance (another payer) or denied by Other Insurance. To ensure they are using only valid codes, we have asked providers to periodically compare the Adjustment Reason Codes they are using with those listed on the Washington Publishing Web site. Please be aware that there have been recent updates to that listing which are now reflected in interChange; **end dated Adjustment Reason Codes will cause claim denials**. Codes that are end dated are noted by a stop date under the Adjustment Reason Code description.

Additionally, providers need to make sure codes ***do not have leading zeros***. Claims will deny for Edit 2516 "Claim adjustment reason code invalid" when a valid adjustment reason code of "2" is entered as "002". Please make sure you have made this update in your claim software.

To access the list of Claim Adjustment Reason Codes:
The Washington Publishing Company Web site can be accessed from www.ctdssmap.com. 1) From the home page click 'Information' 2) Click 'Links' 3) Scroll to 'HIPAA Information' 4) Click on the 'Washington Publishing Company' link or http://www.wpc-edi.com.

- Click on HIPAA
- Click on Code Lists
- Click on Claim Adjustment Reason Codes

Duplicate Denials on Reprocessed Claims

After reviewing your Remittance Advice (RA), it may appear there is an increase in duplicate claim denials. This can occur when claims have been reprocessed by EDS after a system change has been implemented. In order to receive a faster payment, you may have already resubmitted the claim rather than wait for reprocessing. Once the reprocessing takes place, a paid claim is found and produces a duplicate claim denial. To cut down on time spent researching claim denials, please refer to the banner page of your Remittance Advice for details on any claims that have been reprocessed for each cycle. The reprocessed claims start with a specific ICN number. This may give you an answer as to why the claim was a duplicate.

CMS-1500 Medicare Coinsurance/Deductible Billing Instructions for Paper Submission

As a reminder, CMS-1500 claims with Medicare coinsurance and deductible must be submitted to EDS as follows:

CMS-1500 Claim Form Instructions

- Field 1a (Insured's I.D. Number) – If Medicare paid the claim or there is Medicare coinsurance or deductible to be processed, enter the client's **Medicare number** in this field. If Medicare denied the claim, enter the client's 9-digit Connecticut Medical Assistance Program ID.
- Field 9a (Other Insured's Policy or Group Number) - Enter the client's 9-digit Connecticut Medical Assistance Program ID. This field is not required when Medicare has not made a prior payment.
- Field 9d (Insurance Plan Name or Program Name) -

  When Medicare Makes a Payment
  If the client has Medicare and a payment was received:
  - Enter either "Medicare" or "MPB" in this field. If a Medicare Health Maintenance Organization (HMO) is the primary insurer and a payment was received, the words "Medicare HMO" must be indicated in this field.
  - Do **not** enter the amount Medicare paid in this field.
  - The date of the EOMB does not need to be indicated in this field.

  When Medicare Indicates a Denial
  - Enter either "Medicare N/A", "MPB N/A" or "Medicare HMO N/A".
  - Indicate the date of the EOMB in field 9d. (Note: If the provider has a letter from Medicare/CMS stating they are not eligible to enroll in Medicare and that letter is dated within one year from the date of service on the claim, indicate the date of that letter in place of the EOMB date.)

- Field 29 (Amount Paid) – This field should be blank. Do not enter previous Connecticut Medical Assistance Program or Medicare payments for coinsurance or deductible claims in this field.

Explanation of Medicare Benefits (EOMBs) Instructions for Paper Claim Submission
Whether Medicare makes a payment or denies the claim, the EOMB **must** be attached to the paper claim.

When Medicare Makes a Payment

- Attach the Explanation of Medicare Benefits (EOMB), indicating a payment from Medicare or the Medicare HMO, to the claim. Please note that:
  - Providers must submit one paper claim attached to one EOMB.
  - Claims with multiple EOMBs attached to one claim or multiple claims attached to one EOMB will not be processed and will be returned to the provider.
  - The following information must be exactly the same on the paper claim and on the EOMB: patient name, detail dates of service, procedure codes and modifiers (if any), units and billed amounts (each line).
  - The number of lines submitted on the claim must have corresponding lines on the EOMB.
  - Columns that indicate Medicare billed amount, allowed amount, paid amount, coinsurance and deductible must appear on the EOMB.

When Medicare Indicates a Denial

- Attach the Explanation of Medicare Benefits (EOMB), indicating the denial from Medicare or the Medicare HMO, to the paper claim.

Please note that, when submitting a paper coinsurance and/or deductible claim for Connecticut Medical Assistance Program payment, providers may use the copy of the claim submitted to Medicare.

In our next newsletter, look for a reminder on billing instructions for UB-04 claims with Medicare coinsurance and deductible.

Charter Oak Health Plan

(continued from page 1)
Pharmacy and behavioral health providers who participate in the Connecticut Medical Assistance Program and provide services to Medicaid fee-for-service (FFS) or Connecticut Behavioral Health Partnership (CT BHP) clients today can immediately begin to accept Charter Oak clients. For services other than pharmacy and behavioral health, providers will need to enroll with the health plans mentioned below. To learn more about the Charter Oak Health Plan, go to www.charteroakhealthplan.com. To learn more about Charter Oak Behavioral Health (CO BH), covered services, prior authorization, registration and diagnosis requirements, go to www.charteroakbehavioralhealth.com. Value Options is the Administrative Service Organization for Charter Oak behavioral health services and can be contacted Monday through Friday, from 9:00 a.m. to 7:00 p.m. at 1-877-286-2524. To learn more about claim submission for pharmacy and behavioral health services for Charter Oak Health Plan clients, go to www.ctdssmap.com and review the important messages on the Home Page.

Two New Managed Care Organizations (MCO)

(continued from page 1)
The MCOs are responsible for providing all healthcare services with the following exceptions:

- Beginning February 1, 2008 pharmacy services are administered by DSS. Pharmacies now submit claims to EDS for pharmacy services provided to HUSKY A, HUSKY B, Charter Oak and State Administered General Assistance (SAGA) clients who are enrolled in an MCO.

- Effective September 1, 2008, dental services for HUSKY A, HUSKY B and SAGA clients are administered by BeneCare. Dental providers must submit claims to EDS for dental services provided to HUSKY clients enrolled in an MCO and SAGA clients. BeneCare can be contacted at 1-888-445-6665 from 8:00 a.m. to 5:00 p.m. Monday through Friday. There is no dental coverage for Charter Oak.

- Behavioral health services provided by behavioral health providers must be billed to EDS. HUSKY A and B eligible clients are covered under the Connecticut Behavioral Health Partnership (CT BHP). Charter Oak eligible clients are covered under Charter Oak Behavioral Health (CO BH). Value Options is the Administrative Service Organization for all behavioral health services, except for behavioral health services rendered by the primary care provider. For CT BHP clients, Value Options can be contacted Monday through Friday, from 9:00 a.m. to 7:00 p.m. at 1-877-552-8247. For CO BH clients, Value Options can be contacted Monday through Friday, from 9:00 a.m. to 7:00 p.m. at 1-877-286-2524.

The following are the claims mailing addresses and telephone numbers for the three MCOs:

Aetna Better Health, Inc.
1000 Middle Street
Middletown, CT 06457
Phone 1-866-742-3120

AmeriChoice by United Healthcare
400 Capitol Blvd
Rocky Hill, CT 06067
Phone 1-866-573-2451

Community Health Network of CT, Inc.
11 Fairfield Blvd.
Wallingford, CT 06492
Phone 1-800-440-5071

Dental Carve Out Program for Connecticut Medical Assistance Program

Effective September 1, 2008, dental services for all clients currently in HUSKY A and B, and State Administered General Assistance (SAGA) programs will no longer be provided by the Managed Care Organizations (MCOs). All dental services for these clients, as well as Medicaid fee-for-service clients, will be housed under one umbrella and will be managed by a single, not-at-risk Administrative Service Organization (ASO), BeneCare. Providers will be reimbursed by procedure codes on the dental fee schedule dated 4/1/2008 posted at www.ctdssmap.com. The fee schedule lists the pediatric rates, while the reimbursement for clients 21 years of age and over will be at 52% of the listed pediatric rates.

The policy for the dental services under the Connecticut Medical Assistance Program is set by the Department of Social Services (DSS). EDS, as the fiscal agent for DSS, will process claims for dental services provided to all the client populations outlined above. One centralized location for submitting claims for dental services will yield efficiencies for the provider community participating in the program.

The following outlines the responsibilities for EDS and BeneCare in the dental services program under Connecticut Medical Assistance Program.

EDS Responsibilities
- Provider Enrollment
- Claims Processing

Providers can send their paper claims on the original Red ADA-2006 claim form to:

EDS
P.O. Box 2971
Hartford, CT 06104

BeneCare Responsibilities
- Provider Recruitment
- Appointment Assistance for clients
- Care co-ordination/case management
- Client History
- Prior Authorization
- Claims/Medical Policy review

Providers can send their Prior Authorization requests to:

BeneCare Dental Plans
CT Prior Authorization Request
P.O. Box 40109
Philadelphia, PA 19106-0109

Providers can contact EDS Monday through Friday (except holidays) from 8:00 a.m. to 5:00 p.m. toll free at 1-800-842-8440 or local to Farmington, CT at 860-269-2028. The contact information for BeneCare for providers is 1-888-445-6665 and for clients is 1-866-420-2924.

Provider Electronic Solution Reminder

As a reminder, data that can be created using the "list" functionality should not be overlaid with new data. Doing so may cause unnecessary claim denials. As an example, providers who wish to update their billing provider number from their prior Medicaid ID to their NPI should not type the NPI number over or in the field that previously contained their Medicaid ID number. A new billing provider record should be created via the list functionality or by double-clicking on the Provider ID field and completing a new billing provider ID record window. Care should be taken to ensure that the associated qualifier field reflects the input of new data. In following with the above example, when entering the NPI in the "Provider ID" field, the associated "provider ID Code Qualifier", which defaults to 1D must be changed to XX. This is also the case when entering NPI information for other applicable providers such as attending physicians and performing providers. Once the new record is created, providers who chose to copy a prior claim(s) that may contain the old billing provider id, can click on the NPI and save the new billing provider record to their copied claim(s).

Prior Authorization (PA) Search on Provider Secure Web Site

Prior Authorization (PA) search is available via the secure Provider Web Account Home Page. Once signed into your provider secure site, please validate the provider information (NPI and AVRS ID) on your home page. If you have multiple IDs, you will need to match the provider information on the account home page with the provider information tied to your Prior Authorization. On the top of the page, you should see a horizontal listing of menu items; 1) select Prior Authorization and 2) select Prior Authorization Search. The Prior Authorization option is only for providers; if you are signing in as a trading partner, you will not see this as an option. If you signed in as a provider using a clerk ID and you do not see this item, you will need to request access to perform this search function from the primary account holder within your organization.

To initiate a search, you need to enter some of the following information:

Search Fields	Description	If *No Rows Found*
Prior Authorization	Enter the Prior Authorization number. If the PA number is entered, no other fields need to be filled in.	Try searching by Client ID and From Date and Through Date Note: The from date is the date the PA was entered into the system, not the from date of service requested on the PA. If a from date is entered, a through date must also be entered and can be no more than 93 days from the from date.
Client ID and From Date and Through Date	The client's 9-digit Medical Assistance Program ID and From and Through Date must be entered together.	If Authorization doesn't show using From and Through Date based off of the Date of Service (DOS), extend the Through Date up to 93 days. Authorization search looks for the date the PA was entered into the interChange system not DOS.
NDC, Procedure, Status, PA Assignment and Revenue Code	These fields can only be used to narrow the search results after using one of the two methods listed above.	N/A

Clarification For Pharmacies on Other Insurance Coverage

EDS continues to receive inquiries about the proper values to submit on a pharmacy claim when there is a primary insurance before Medicaid.

Commercial Insurance

When the client of a Connecticut Medical Assistance Program has a private insurance, that information needs to be transmitted on the claim. Failure to transmit the information will result in a denial to "Bill Private Carrier First". The **Other Coverage Code** field must contain one of the following values:

02 - Other coverage exists
If the Primary makes a payment, the value of 02 should be indicated on the claim.

03 – Other coverage exists, claim not covered
If the claim is denied by the Primary payer, the value of 03 should be indicated on the claim.

04 – Other coverage exists, payment not collected
If the Primary adjudicates the claim with all reimbursement assigned to the client as a co-pay, a value of 04 should be indicated on the claim.

****** THE VALUE OF 8 SHOULD NEVER BE SUBMITTED ON A CLAIM WITH A PRIVATE INSURANCE. THIS VALUE IS USED WITH MEDICARE PART D COVERAGE ONLY******

(article continued on page 7)

(continued from page 7)

In addition to the Other Coverage Code, you must also submit the Other Insurance ID Qualifier of 99 (this value is used for all other payers), and the Other Insurance Carrier Code assigned to the Primary Insurance. The complete list of Carrier Codes can be found on the Web site at www.ctdssmap.com > Publications > Provider Manuals > Carrier Listings.

Provider Manuals

Chapter	Title
1	Introduction
2	Provider Participation Policy
3	Provider Enrollment and Re-enrollment
4	Client Eligibility
5	Claim Submission Information **Additional Chapter 5 Information** • Carrier Listing Sorted by Name • Carrier Listing Sorted by Carrier Code

Pharmacy providers are requested to contact the Department of Social Services when inaccurate or outdated TPL coverage exists for a Medicaid fee-for-service, HUSKY A or SAGA client. The pharmacy is asked to call the Department of Social Services' **Third Party Liability Unit at 860-424-5975** and provide: client's name, client identification number, the health insurance company, a description of the specific problem, pharmacy telephone number and pharmacy contact information. This information can also be **faxed to the Department's Third Party Liability Unit at 860-424-5333**.

Medicare Part D

The only Other Insurance values accepted when Medicare Part D is the primary payer are:

08 – Co-pay only claim

If Medicare Part D pays the claim, the value of 08 must be submitted in the Other Coverage Code field on the claim.

** If a Medicaid or a ConnPACE client deemed eligible for Low Income Subsidy (LIS) has a co-pay submitted that exceeds the allowed threshold, the claim will be denied. To rectify this situation, the pharmacy must contact the Medicare Part D sponsor and notify them of the client's LIS or Dual eligibility status. Once the Medicare Part D sponsor verifies and updates their file, the correct co-pay should be reflected by the Part D plan's transmission.

03 - Other coverage exists, claim not covered

If Medicare Part D rejects the claim for a non-formulary medication or Prior authorization requirement, the value of 03 should be submitted on the claim, **along with the MED D rejection code**. The **ONLY** rejection code values accepted are:

3W - Prior Authorization in Process
3Y - Prior Authorization Denied
70 - Product/Service Not Covered
75 - Prior Authorization Required

Undocumented use of these rejection codes can potentially result in the recoupment of claims.
In addition to the Other Coverage Code, you must also submit the Other Insurance ID Qualifier of 99 (this value is used for all other payers), and the Other Insurance Carrier Code of MDD assigned to all Medicare Part D sponsors.

Electronic Data Systems Corporation
Box 2991
Hartford, CT 06104

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Call Center News!!

EDS would like to advise providers of changes to the Provider Assistance Call Center AVRS call flow. Currently the main menu options are:

Option One – Dental Inquiries
Option Two - Pharmacy Inquiries

Once a caller has selected an inquiry option for either of the above types, the call will be routed directly to the most appropriate and knowledgeable customer service representative. Please continue to listen closely to the main menu as the options are subject to change.

Provider Manual Chapters Updated

Provider manual chapters are continually revised as program changes are implemented or clarifications are identified. The following chapters have been updated since the interChange system was implemented in February 2008:

- Chapter 1 Introduction
- Chapter 4 Client Eligibility
- Chapter 6 Electronic Data Interchange Options
- Chapter 8 Dental
- Chapter 8 Professional Services
- Chapter 9 Prior Authorization

EDS Holiday Schedule

Thanksgiving	November 27, 2008
Thanksgiving	November 28, 2008
Christmas	December 25, 2008

Please 1) access the Web portal at www.ctdssmap.com 2) select Information and 3) select Publications to download the latest version of these chapters.