December 2021
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- **Physicians, Physician Assistants, Advanced Practice Registered Nurses, Certified Nurse Midwives, Medical Clinics, Family Planning Clinics, Dialysis Clinics, Federally Qualified Health Centers (FQHCs), Outpatient Hospitals, Hospice Agencies, Home Health Agencies, Dentists, and Pharmacy Providers:**
  COVID-19 Vaccine Administration

- **Acupuncturists:**
  Enrollment of Independent Acupuncture Providers in the Connecticut Medical Assistance Program

- **Outpatient Hospital, Long Term Care, Home Health, Transportation, Radiology, Therapist, Inpatient Hospital, Psychiatric Outpatient Hospital, Ambulatory Surgical Center Clinic, Rehabilitation Facility Clinic, and Free-standing Renal Dialysis Clinic Providers:**
  Outpatient Crossover Claim Pricing Changes

- **All Providers Billing Outpatient Crossover Claims, Except Federally Qualified Health Centers:**
  Coming Soon! Outpatient Crossover Electronic 837I Claim Submission and Pricing Changes

- **Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC), Personal Care Assistance (PCA), Mental Health (MHW) Waiver Service Providers and Home Health Agencies:**
  Electronic Visit Verification—Face or Fingerprint Login

- **All Providers:** Quarterly or Annual Health Insurance Portability and Accountability Act (HIPAA) Updates

- **All Physicians:** Important Reminders to Physicians regarding Consent to Sterilization Form Submission

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Attention: Physicians, Physician Assistants, Advanced Practice Registered Nurses, Certified Nurse Midwives, Medical Clinics, Family Planning Clinics, Dialysis Clinics, Federally Qualified Health Centers (FQHCs), Outpatient Hospitals, Hospice Agencies, Home Health Agencies, Dentists, and Pharmacy Providers

COVID-19 Vaccine Administration

Important bulletins have been posted this quarter to instruct providers on billing requirements for both the COVID-19 vaccine administration of booster doses and the COVID-19 vaccine for pediatric administration. The bulletins include the procedure codes, effective dates, and rates for the administration of those vaccines. This information is consistent with the Food and Drug Administration (FDA) Emergency Use Authorization (EUA), effective for dates of services referenced in the bulletins and through the end of the federal public health emergency (PHE). Providers should refer to PB 21-89 and PB 21-91 for detailed information.

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Attention: Acupuncturists

Enrollment of Independent Acupuncture Providers in the Connecticut Medical Assistance Program

In accordance with recently enacted state law in section 331 of Public Act 21-2 of the June 2021 Special Session, effective for dates of service October 1, 2021 and forward, the Department of Social Services (DSS) began to cover services rendered by independent acupuncturists in the office setting. To be eligible for reimbursement under Medicaid, the acupuncturist must be licensed by the State of Connecticut Department of Public Health (DPH) and enroll as an independent acupuncturist with HUSKY Health.

Acupuncture services are covered for all Connecticut Medical Assistance Program members under HUSKY A, C, and D. Please note that services provided by acupuncturists in independent practice continue to be non-covered under the HUSKY B benefit plan.

Acupuncturists and acupuncturist groups can enroll as billing providers via the enrollment Wizard on the www.ctdssmap.com Web site. Acupuncturist groups must also enroll and affiliate individual acupuncturists to submit claims for services rendered to Medicaid members. The individual acupuncturist must appear on the claim as the "Rendering Provider" otherwise the claim will deny.

The Acupuncture Fee Schedule is available on the www.ctdssmap.com Web site under Provider > Provider Fee Schedule Download.

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Attention: Outpatient Hospital, Long Term Care, Home Health, Transportation, Radiology, Therapist, Inpatient Hospital, Psychiatric Outpatient Hospital, Ambulatory Surgical Center Clinic, Rehabilitation Facility Clinic, and Free-standing Renal Dialysis Clinic Providers

Outpatient Crossover Claim Pricing Changes

Outpatient Hospital providers, effective September 1, 2021, and Long-Term Care, Home Health, Transportation, Radiology, and Therapist Providers, effective November 1, 2021, are reminded that outpatient claims that crossover directly from Medicare or that are submitted by the provider with Medicare information at the claim detail will now be priced using the information that is submitted at the detail level. The same will apply to Inpatient Hospital, Psychiatric Outpatient Hospital, Ambulatory Surgical Center Clinic, Rehabilitation Facility Clinic, and Free-standing Renal Dialysis Clinic Providers, effective January 1, 2022.

Additionally, providers submitting Medicare information at the claim detail are reminded that they can now submit copay information, using claim adjustment reason code (CARC) of 3. The following shows the ASC X12N 837 I Health Care Claim loop and segment where that CARC may be submitted. Loop Segment Description 2430 CAS Claim Adjustment – Enter the co-insurance (claim adjustment reason code = 2), deductible (claim adjustment reason code = 1), or copay for outpatient crossovers only (claim adjustment reason code = 3) for the claim. As a result of these changes, providers may see slight differences in their crossover claim payments.

Providers with a provider type above may refer to the following provider bulletins for additional information: PB 21-74 and PB 21-88.

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Attention: All Providers Billing Outpatient Crossover Claims Except Federally Qualified Health Centers (FQHCs)

Coming Soon! Outpatient Crossover Electronic 837I Claim Submission and Pricing Changes

No claim submission changes are currently required for any providers that may not be submitting Medicare information at the detail level. However, that will be required in the future. Chapter 11 of the Provider Manual, available via the www.ctdssmap.com Web site by selecting Information > Publications and selecting the appropriate claim type from the drop-down box, outlines the ASC X12N 837I loops and segments needed to submit the Medicare information at the detail level. Trading partners/providers are encouraged to begin to make necessary changes to support the above requirements now. Additional provider notification will be distributed with implementation timeframes and instructions on how to submit the required claim detail information.

Additionally, changes will be made to the Web claims submission panels available via a provider's Secure Web portal account when logged on via www.ctdssmap.com to allow providers to submit Medicare information at the claim detail. Providers will be notified when those changes are available. Adequate time will be allotted for providers to make the changes required to submit Medicare information at the claim detail. However, upon implementation, if that information is not submitted at the claim detail, providers will experience claim denials.

Providers may refer to the following provider bulletin for additional information: PB 21-95.

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Attention: All Providers

Change to Email Box Addresses

Gainwell Technologies is pleased to announce that email boxes have migrated from @dxc.com to @gainwelltechnologies.com. While emails sent to @dxc.com will auto forward for a short period of time, providers are encouraged to begin using the @gainwelltechnologies.com email addresses. (As an example, ctxixhosppay@dxc.com is now ctxixhosppay@gainwelltechnologies.com.) Documentation will be updated to reflect the correct email addresses.

Attention: Acquired Brain Injury (ABI), Connecticut Home Care (CHC), Mental Health (MHW), Personal Care Assistance (PCA) Waiver Providers and Home Health Agencies

Electronic Visit Verification—Face or Fingerprint Login

Effective December 3, 2021, SMC (Sandata Mobile Connect) app users may log in to the app without entering a password by using either face or fingerprint identification stored on their mobile device. Apple (iOS) users will be able to utilize their Face ID or Touch ID (depending on their mobile device) and Android users will be able to use their device's fingerprint scanner. The SMC update for the enhancement was released November 18, 2021 but may take up to two (2) weeks to appear in the Google Play or App Store. The SMC app will then need to be upgraded for the Task to Service enhancement to be applied. Please check your app store for the update and upgrade your SMC app as soon as it is available. Once enabled, a user may log in by scanning their face or fingerprint, depending on the type of mobile device they have. The functionality is enabled by default and can be enabled or disabled on the SMC setting screen.

Please note, you will still require a password. Even if you choose to utilize the face or fingerprint login feature, normal rules for password reset and expiration still apply. When your password expires and you log in using the face or fingerprint feature, you will be prompted to reset your password.

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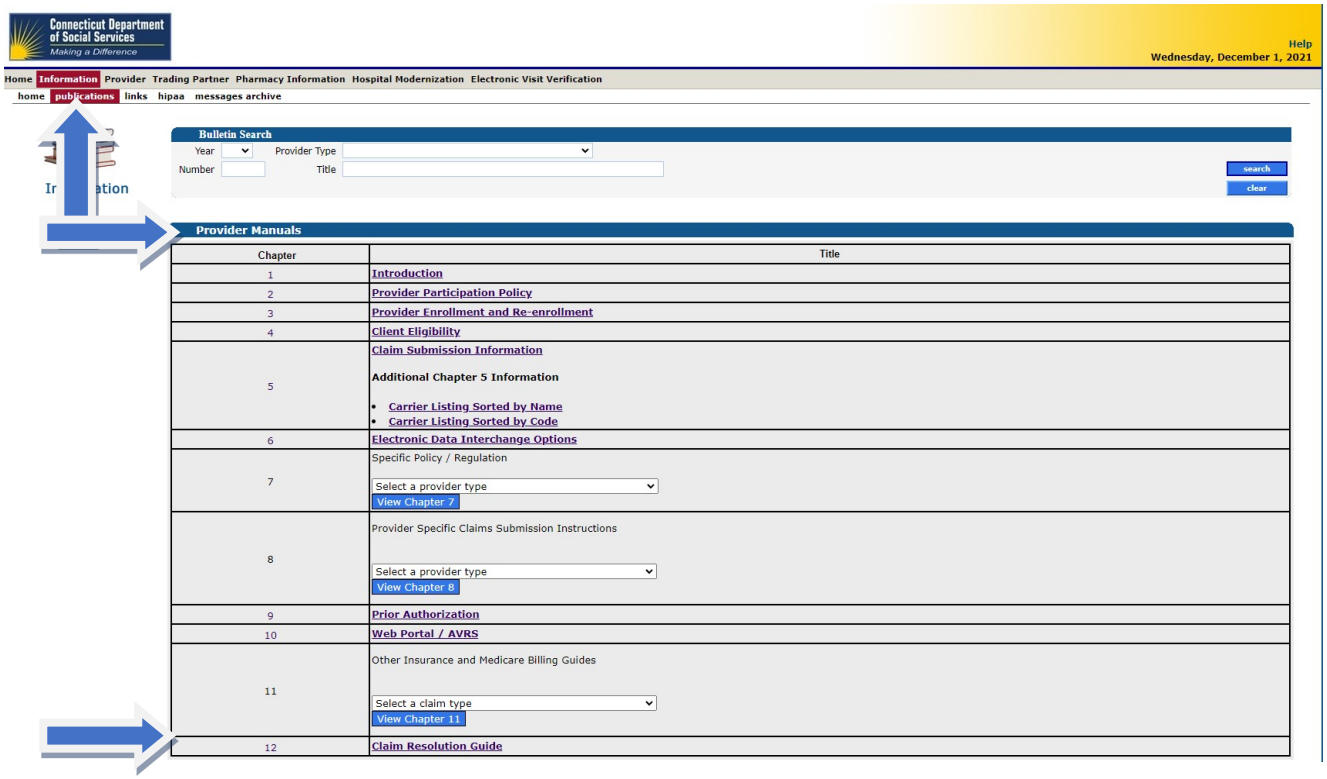
How to Resolve Claim Denials

Do you ever need a resource on how to resolve claim denials? Providers are reminded that Chapter 12 Claim Resolution Guide, available on the www.ctdssmap.com Web site under Information > Publications, Provider Manuals, Chapter 12 Claims Resolution Guide, can be a great resource to determine if/how to resolve claim denials. Providers should be familiar with section 12.1 Overview to ensure the intended use of this chapter before proceeding to section 12.2 Explanation of Benefit (EOB) Codes. The EOB codes are listed in numeric order. If a code is not found, it has not yet been documented in Chapter 12. Providers may contact Gainwell Technologies to request an EOB code(s) be added to the chapter.



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Attention: All Providers

Quarterly or Annual Health Insurance Portability and Accountability Act (HIPAA) Updates

It is that time of year when the Department of Social Services incorporates updates to the Healthcare Common Procedure Coding System (HCPCS) and Current Dental Terminology (CDT) to remain HIPAA compliant. Providers are strongly encouraged to monitor new bulletins for additions, changes or deletions to codes as a result of these updates.

Updated fee schedules are posted to reflect the updates and can be accessed and downloaded from the Connecticut Medical Assistance Program (CMAP) Web site: www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download". Click on the "I accept" button and proceed to click on the appropriate fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open".

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Timely Filing Claim Submission Reminders

It is the provider's responsibility to ensure that all claims for services provided to a client are submitted within one (1) year from the actual date of service.

Claims nearing the timely filing limit pending service authorization should be submitted to avoid timely filing. The claim will deny for PA required, however, when service authorization is in place, the claim may be resubmitted without the need for timely filing override approval and special handling.

Claims nearing the timely filing limit pending TPL response (payment or denial) should also be submitted to avoid timely filing. The claim may deny due to bill Medicare or other Carrier first, however, if payment or denial from Medicare and/or the other carrier is received within one year of the Remittance Advice denial date, the claim may be submitted without the need for timely filing override approval and special handling.

Providers must research and resolve all claim issues by reviewing the Connecticut Medical Assistance Program Remittance Advice (RA) each time it is sent to the provider. Claims that are not resolved within one year of the last submission should be resubmitted to ensure timely filing status.

Claims sent to Gainwell Technologies beyond the timely filing limit that have invalid documentation to override the timely filing limit will appear on the provider's RA with the Explanation of Benefits (EOB) message "Claim exceeds timely filing limit." Providers are no longer required to submit claims on paper that exceed timely filing when documentation exists that waive the timely filing limit.

DSS does not accept claims submitted on paper with the exception of special handled claims.

A paper PCAR is no longer required to return funds via a claim adjustment. Providers may submit an electronic adjustment or Web claim adjustment to return funds without the claim denying in full for timely filing.

Exceptions that Waive the Timely Filing limit

DSS has directed Gainwell Technologies to waive the timely filing limit if the following conditions exist. **PLEASE NOTE: Claims do not need to be submitted on paper to override the timely filing rule.**

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Providers have **one (1) year** from the paid date (claim cycle date) indicating a denial to resubmit the claim, provided the denial was not for timely filing.

The date of service on the claim must fall within **one (1) year** of the issue date on the other insurance denial, if applicable, providing the denial was not for timely filing.

As a reminder, Carriers who historically do not respond with either payment or denial within DSS timely filing limits should be sent a subrogated claim. Providers should refer to Chapter 5, section 3 to review the subrogation process, beginning with the Legal Notice of Subrogation (W81), to facilitate other carrier response and reasonable attempts to obtain third party payment, prior to submitting the claim to the Connecticut Medical Assistance Program (CMAP), with the Third-Party Billing Attempt Form (W-1417).

The provider has one (1) year from the date the client's eligibility was added to the Connecticut Interchange Medicaid Management Information System (MMIS).

Providers may contact Gainwell Technologies Provider Assistance Center to obtain add dates for retroactive client eligibility.

For all other exceptions, Gainwell Technologies will validate that the condition exists to override timely filing via the data submitted on the claim and the provider's past claim submission history.

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Attention: All Providers

Optimize Your Connecticut Medical Assistance Program Experience

Optimize your Connecticut Medical Assistance Program Experience by following these important reminders:

Use Microsoft Edge or Google Chrome as your Web browser

Due to the discontinuation of Internet Explorer support, providers are reminded that they should use Microsoft Edge or Google Chrome when accessing the Connecticut Medical Assistance Program Web site at www.ctdssmap.com. Providers are highly encouraged to use either of these tools in place of Internet Explorer, which is no longer supported. It is recommended that providers not switch between Edge/Chrome and Internet Explorer to perform various functions, as this could cause issues.

Clear your Cache

It is recommended that providers take actions such as clearing their cache to optimize system performance.

Don't wait until the day prior to a Financial cycle to submit claims.

The day prior to a financial cycle tends to be a high usage day where providers may experience slower response times. Submitting claims on the day prior to the cycle may not provide sufficient time to submit or correct and resubmit a file in the event of a file failure or connectivity issue.

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Attention: Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC), Personal Care Assistance (PCA) Waiver Service Providers

Provider Training Available

As part of our yearly training program, Gainwell Technologies once again offered virtual Waiver Service Provider Refresher workshops to Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) and Personal Care Assistance (PCA) Waiver Service Providers. If you or your staff missed the training, the Power Point Presentation is available on the www.ctdssmap.com Web site. From the Home page, click the "Provider Training" link. Under the "Materials" heading, for the latest Waiver Service Provider Refresher Workshop, click on the "Waiver Provider Refresher Workshop 2021" link.

This workshop offers a review of 2021 Waiver Program and Electronic Visit Verification (EVV) updates as well as many key elements necessary to successfully becoming an enrolled Waiver Service provider, maintain an active enrollment status, in addition to maximizing reimbursement for services provided via successful claim submission. This workshop furthermore reviews the tools, resources, and contacts available to ensure on-going success by keeping you informed and minimizing rework by knowing where to find the information or who to contact to help you get the job done! You will also find a copy of each Waiver Procedure Code Crosswalk to provide you with important service authorization, billing and EVV information related to the services available under each Waiver Program.

If you are interested in specific Waiver Program information, click on past Waiver Specific Workshop links under each of the Waiver Workshop headings noted above.

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Attention: All Physicians

Important Reminders to Physicians on Consent to Sterilization Form Submission

Providers are reminded that the federal Consent to Sterilization Forms are available in both English and Spanish on the www.ctdssmap.com Web site, under Information > Publications > Forms (Authorization/Certification Forms section). Consent forms must be submitted as soon as they are completed in order to prevent claim processing delays.

Fax to:

(860) 986-7995

Mail to:

Gainwell Technologies

P.O. Box 2971

Hartford, CT 06104

Claims will remain in a suspended status for 90 days until an accurately completed Consent form is received. If a form is received by Gainwell Technologies that is not accurately completed, that form will be returned by mail to the address of the provider that submitted the suspended claim. Therefore, it is also important to ensure address information is reviewed on a frequent basis, with any necessary updates to existing addresses being applied via the provider's Secure Web portal account. To update an address, log in to your Secure Web portal account at www.ctdssmap.com and select Demographic Maintenance.

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Appendix

Holiday Schedule

Date	Holiday	Gainwell Technologies	CT Department of Social Services
12/24/2021	Christmas, observed	Closed	Closed
12/31/2021	New Year's Day, observed	Closed	Closed
1/17/2022	Martin Luther King Jr. Day	Closed	Closed
2/11/2022	Lincoln's Birthday, observed	Open	Closed
2/21/2022	Presidents' 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.

PB21-108 Updates to the Reimbursement for Physician-Administered Drugs, Immune Globulins, Vaccines and Toxoids

PB21-107 1. January 2022 Quarterly Medical Clinic HIPAA Compliant Update: 2. Updates to the Reimbursement of Physician Administered Drugs, Immune Globulins, Vaccines and Toxoids in Medical Clinics

PB21-106 First Quarter 2022 HIPAA Update—Changes to the Medical Surgical Supply (MSS) Fee Schedule

PB21-105 1. January 2022 Quarterly HIPAA Compliant Updates-Physician-Office and Outpatient, Physician Anesthesia And Surgical Fee Schedules 2. Physician Administered Drug Reimbursement 3. Manually Priced Procedure Codes

PB21-104 January 2022 Quarterly HIPAA Compliant Update—Independent Audiology and Speech and Language Pathology Fee Schedule

PB21-103 (1) Quarterly Update: January 2022 HIPAA Compliant Updates to Freestanding Ambulatory Surgical Center Fee Schedule (2) Addition of Bariatric Surgery Codes to the Clinic Ambulatory Surgical Center (ASC) Fee Schedule

PB21-102 January 2022 Independent Radiology and Physician-Radiology Fee Schedules—Quarterly HIPAA Compliant Update

PB21-101 January 2022 Quarterly HIPAA Compliant Update-Consolidated Laboratory Fee Schedule

PB21-100 January 2022 Quarterly Dental Fee Schedule HIPAA Compliant Update

PB21-99 Requirements for Coverage of Over-the-Counter Nutritional Supplements for Clients in the WIC Program and Medicaid

PB21-98 Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients

PB21-97 1) January 1, 2022 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

PB21-96 Outpatient Crossover Claim Pricing Changes

PB21-95 Outpatient Crossover Electronic 837I Claim Submission And Pricing Changes

PB21-94 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)

PB21-93 Rate Increase on Select Behavioral Health Services

PB21-92 Pediatric Inpatient Psychiatric Services: Interim Voluntary Value-Based Payment Opportunity for Increasing Needed Capacity and Interim Rate Add-On for Acuity

PB21-91 CMAP COVID-19 Response Bulletin 57: Authorization Of Pfizer-BioNTEch COVID-19 Vaccine for Pediatric Administration (ages 5-11 years)

PB21-90 Billing Laboratory Fees for Medicaid Eligible Members In Residential Substance Use Disorder Treatment Facilities

PB21-89 CMAP COVID-19 Response Bulletin 56: Booster Doses COVID-19 Vaccine Administration

PB21-88 Outpatient Crossover Claim Pricing Changes

PB21-87 Updated Provider Policy: Wheelchair-Mounted Assistive Robotic Arm Attachment

PB21-86 Rescinding: Provider Policy—Wheelchair-Mounted Assistive Robotic Arm Attachment

PB21-85 Connecticut Housing Engagement and Support Services (CHESS)

PB21-84 1) 4th Quarter 2021 HIPAA Update—Changes to the Durable Medical Equipment (DME) Fee Schedule 2) Establish Max Fee for Non-Sterile Gloves

PB21-83 Billing Guidance for Chimeric Antigen Receptor (CAR-T) Cell Treatments

PB21-82 Electronic Visit Verification (EVV)—Task to Service Enhancement

PB21-81 Advanced Practice Registered Nurses and Physician Assistants Authorized to Order Home Health Services

PB21-80 Policy Updates and Changes to Clinical Review Criteria

PB21-79 1. Quarterly HIPAA Compliant Update-Physician Office and Outpatient Fee Schedule; 2. Increasing the Reimbursement For Select Long-Acting Reversible Contraceptive Devices; 3. Adding Enhancing Agent for Ultrasounds to the Physician Office and Outpatient Fee Schedule

PB21-78 Supplementing Guidance for Treatment Planning and Radiographic Imaging Requirements

PB21-77 Hospice Rates for Federal Fiscal Year 2022

PB21-76 Family Planning Clinic Fee Schedule-October 2021 Quarterly HIPAA Compliant Update

PB21-75 Revision of Rates for Certain Clinical Diagnostic Laboratory Testing Codes

PB21-74 Outpatient Crossover Claim Pricing Changes

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

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