Connecticut Department of Social Services
Caring for Connecticut

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

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

HIPAA 5010 Information
Provider Electronic Solutions Software Users
Additional Processor Control Numbers (PCNs) Added for NCPDP Version D.0 Claims Processing
Claim Resolution Guide

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All Providers

HIPAA 5010 Implementation

The Department of Social Services (DSS) and HP are preparing to implement the new 5010 version of the X12 HIPAA Transaction and Code Set Standards. Please review the following **To Do List** carefully to learn what you or your organization should do now to prepare. Your early participation in this implementation will avoid unnecessary claim denials and will ensure a smooth transition to these new requirements.

To Do List

- Contact your billing agency, software vendor or clearing house to ensure that they are upgrading their products to support HIPAA 5010 and NCPDP D.0.
- Providers with subparts who have enumerated NPI(s) must use the NPI assigned to each subpart when submitting claims to all payers.
- Upgrade your HP Provider Electronic Solutions software now to the current 3.76 version to ensure a smooth transition to the upcoming 3.77 5010 version of the software. See Provider Electronic Solutions Software article in this newsletter for more details.
- Make sure your Primary Address does not include a P.O. Box and your zip code is a full nine digits. This can easily be completed by logging onto your main account user's secure Web account on www.ctdssmap.com and clicking on the Demographic Maintenance tab. Click on Location Name Address below the Provider Information panel, click on the Service Location row, click maintain address on the right, update the address and click save. Providers may also write a letter, on company letterhead, indicating your NPI and send the address change to HP Provider Enrollment, P.O. Box 5007, Hartford, CT 06104.
- Stay informed!! View the HIPAA Important Message on the home page of www.ctdssmap.com to obtain updates to DSS' HIPAA 5010 implementation plan. **All future notifications and bulletins will only be posted to this Web site and will not be mailed to the provider community.**

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Do You Need a Better Explanation of Our Explanation of Benefit (EOB) Codes?

EOB codes are posted to claims to provide a brief explanation of the reason why claims were either suspended or denied. The EOB codes are also used to explain any discrepancies between amounts billed and amounts paid on paid claims. A new Chapter 12 to the Provider Manual, titled the Claim Resolution Guide, will soon be available to provide a detailed description of the cause of the most common EOB's and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition. Of course, not all error conditions can be resolved, such as a claim that exceeds the timely filing limit, but this guide should help with common billing errors that can be easily corrected. When published on the www.ctdssmap.com Web site, this chapter will also be accessed by clicking on Information, then Publications and scrolling down to Claims Processing Information.

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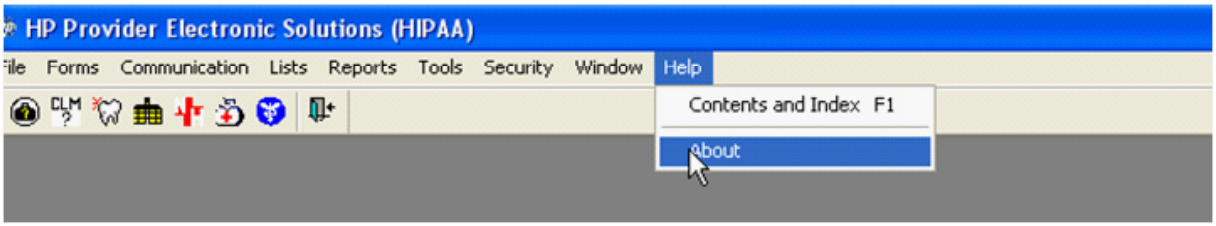
All Providers

Attention Provider Electronic Solutions Software Users

Providers must be running the current 3.76 4010 version of Provider Electronic Solutions software before their software can be upgraded to the new 3.77 5010 version when it becomes available.

Providers should take the following steps to prepare for the new 5010 version.

1. To determine which version you are currently using, open the software, then go to Help, then About. To upgrade to version 3.76, you may need to do one or more sequential upgrades. Before performing an upgrade, it is recommended that you back up your database.



2. To back up the software's database, locate the file named **ctnewesc.mdb** in your C:\cthipaa folder. Copy the file ctnewesc.mdb to a flash drive, CD or to your desktop. If the ctnewecs.mdb is not located in your C:\cthipaa folder, you will need to contact your system administrator for assistance in locating the database file in order to back it up.

3. Once the database is backed up, the upgrade(s) process may begin. Important: Please remember that you must perform upgrades in order. For example, if you are currently running version 3.74, you will need to upgrade to Version 3.75, then upgrade to 3.76. Please refer to the Web site at www.ctdssmap.com for detailed instructions and steps for upgrading. Once on the home page, click on Trading Partner, EDI, and click on the link for either "Upgrade Instructions via the Web" or "Upgrade Instructions via Provider Electronic Solutions".

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DME Providers

Is the National Correct Coding Initiative Having an Impact on Your DME Claim Submissions?

Are you experiencing a higher rate of claim denials? Have your billed quantities been cut back? Chances are you have not changed your billing practices and National Correct Coding Initiative (NCCI) edits are impacting your claims. For more information on the NCCI and Medically Unlikely Edits (MUEs), please refer to Provider Bulletin PB10-57 'CMS National Correct Coding Initiative (NCCI)'.

What can you do to limit the impact on your claims?

- Identify whether modifier RT - Right or LT - Left is applicable to the procedure code to identify which side of the body the service is for and if applicable submit the correct modifier on your claim.
- If a service is provided for both the right and left sides on the same date of service, the code should be billed with modifier RT on one line and the same code with modifier LT on the next line. If you continue to bill multiple units on the same detail, the units will be cut back and only pay for one.
- Rental claims for medical equipment identified for a side of the body must also include modifier RT or LT and be billed on separate details if multiple units were provided on the same date of service.

Now that you have identified how your claims processed, how can you make your corrections? The quickest method of resolution is to logon to your secure provider account on the Connecticut Medical Assistance Web site:

- Execute a claim inquiry
- Go into the detail
  - add the applicable modifier; and/or
  - decrease the number of units (if another detail needs to be added);
- Add a second detail if billing for multiple units; be sure to add the correct modifier(s) to each
- Scroll to the bottom of the claim and click the submit button for a previously denied claim, or adjust for a previously paid claim.

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Clinic Providers

CMS Web Site Update: Acceptable Documentation in Lieu of Medicare "Suppliers Not Eligible to Participate" Denial Letters for Clinic Services

CMS recently made updates to their Web site and moved this document. Please note the following new Web manual information:

DSS has agreed to accept a copy of the list of suppliers not eligible to participate in Medicare as valid Medicare denial documentation, in lieu of the Medicare 'Not Eligible To Enroll' denial letters for clinic services requested through NGS. The list is documented in the Medicare Provider Integrity Manual, Publication # 100-8, under Chapter 15, Section 15.4.8 which is located on the CMS Web site, www.cms.hhs.gov/Manuals/IOM. A copy of this page must be stored in the client's file for audit purposes and does not need to be submitted with the claim to HP. The Medicare denial date submitted on the claim would represent the date the documentation was printed. Each year the provider must validate this list to ensure it continues to be valid documentation for future claims.

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Additional Processor Control Numbers (PCNs) Added for NCPDP Version D.0 Claims Processing

The Centers for Medicare and Medicaid Services (CMS) has mandated a change to electronic transactions and code sets which requires pharmacy claims to transition from National Council for Prescription Drug Programs (NCPDP) Version 5.1 to Version D.0. by January 1, 2012.

An important change in processing D.0 claims is the need for new Processor Control Numbers (PCNs).

Please Note: Claims submitted in the current NCPDP Version 5.1 **are not** impacted by the addition of PCNs and changes should not be made to incorporate them into your version 5.1 software. Continue using the current PCNs until you update your Point of Sale (POS) systems to Version D.0.

All Medicare Part D primary paid claims are required to be captured in order to effectively report and coordinate a beneficiary True Out-Of-Pocket (TrOOP) cost to the Troop Facilitator. In order to achieve this, additional Processor Control Numbers (PCNs) will be utilized for Version D.0 claim processing. The PCNs along with a description of the applicable program/primary coverage combination for utilization are identified in the chart below:

PCN	Connecticut Medical Assistance Program Benefit Coverage	Other Insurance	Other Coverage Code (OCC)	Comment
VAN/ Vendor assigned PCN	All programs: FFS, Medicaid LIA, HUSKY, ConnPACE, CADAP, Charter Oak	No other coverage primary to the CT Medical Assistance Program coverage	N/A	Same PCN currently used for FFS, Medicaid LIA, HUSKY, Charter Oak claims processing
CTPCNPTD	ConnPACE, CADAP	Medicare Part D	8 - Claim is a billing for patient financial responsibility only 3 - Coverage Exists –claim not covered	Same PCN currently used for ConnPACE/CADAP claims processing
CTPCNPVT	All programs: FFS, Medicaid LIA, HUSKY, ConnPACE, CADAP, Charter Oak	Private/ Commercial Third Party Liability (TPL) coverage *Medicare Part B primary denials	2 - Coverage Exists –payment collected 3 - Coverage Exists –claim not covered 4 - Coverage Exists payment not collected	**NEW PCN** for all individuals with commercial insurance coverage regardless of payment or denial OCC 3 Only for Medicare Part B primary claims
CTPCNFMD	FFS, Medicaid LIA, HUSKY, Charter Oak	Medicare Part D	8 - Claim is a billing for patient financial responsibility only 3 - Coverage Exists –claim not covered	**NEW PCN** for individuals with Medicare Part D primary and program coverage other than ConnPACE/CADAP

For additional information on changes due to the transition to NCPDP Version D.0, please refer to Provider Bulletin PB-11-10 'HIPAA 5010 Changes for Pharmacy Transition to NCPDP Version D.0'. To access the bulletin from the Web site Home page, go to Information, Publications, enter PB11-10 in the Bulletin Number field, and click search. Links to documents outlining the HIPAA 5010 changes for all transactions are also available on the Web site. From the Home page, go to Information, HIPAA, and click on the desired link.

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Pharmacy Providers

Refills of Existing Prescriptions for New Medications Added to the Preferred Drug List (PDL) Require Prior Authorization (PA)

As was previously communicated in Provider Bulletin PB10-56 "October 1, 2010 Changes to the Connecticut Medicaid Preferred Drug List (PDL)"and PB10-74 "January 1, 2011 Changes to the Connecticut Medicaid Preferred Drug List (PDL);" Prior Authorization (PA) is required when any **new** or **refill** prescription is filled for a non-preferred product.

Effective January 3, 2011, any pharmacy claim submitted for a non-preferred medication, regardless of the refill indicator (new prescription or a refill of an existing prescription) will deny with Explanation of Benefit (EOB) code 3101 'Non-Preferred; Contact MD or HP for PA.'

The pharmacist should consult with the prescriber to see if a preferred drug can be prescribed as an alternative, or explain that the prescriber must obtain and receive PA from HP before a non-preferred medication can be dispensed.

In the event that the prescriber could not be reached, please refer to the previously referenced bulletins for the method of obtaining an auto-PA for a one time 14 day supply of the medication.

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Transportation Providers

Ambulance Fractional Mileage is Not Required for Medicaid Claims

On November 19, 2010 the Centers for Medicare and Medicaid Services (CMS) issued Transmittal # R2103CP which notifies ambulance providers that effective with dates of service January 1, 2011 all mileage submitted to Medicare must be submitted with fractional mileage. This new requirement does not apply to claims submitted to the Connecticut Medical Assistance Program and providers should continue to round up mileage to the nearest whole mile. Medicare crossovers claims received with fractional mileage will not be affected and will continue to pay coinsurance and/or deductible due.

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Long Term Care Providers

Patient Liability Adjustments for Long Term Care Providers

Providers should not use Web Claim submission to adjust claims for patient liability changes. When a patient liability change is made by the Department of Social Services (DSS), all claims that are associated with that change will systematically adjust in the month following the update. Patient Liability mass adjustments are made during the first cycle of every month. For example if your client's patient liability was adjusted on January 3, 2011 for the months of September 2010 to present, the paid claims for the month of September through December will be adjusted during the first cycle in February. If you are expecting a claim to be adjusted and the adjustment did not show on your Remittance Advice (RA), please contact the Provider Assistance Center at 1-800-842-8440 to check the client's patient liability in the system. If HP does not reflect the change in the system, please contact the regional worker to verify the update was made.

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Nursing Home and Hospice Providers

Hospice Client Eligibility

Nursing Home and Hospice Providers are reminded that a Hospice lock-in eligibility segment may not exist or span all dates of service on some of their clients who previously or currently reside in a nursing facility while receiving Hospice care. This occurs when the Department of Social Services (DSS) does not receive a completed Hospice election form or does not receive the election form in a timely manner from the Hospice Provider. As a reminder, a Hospice lock-in is not back dated in order to prevent claim denials for other providers who may have provided hospice related services, without knowledge of the client's election.

In addition, Hospice providers may have received payment for nursing facility charges during these periods of ineligibility. To correct this error, HP modified their system and recouped Hospice claims for nursing facility charges when a Hospice lock-in segment was not present on the client's eligibility file for the dates of service paid. These claims were recouped from the Hospice provider in the August 24, 2010 financial cycle with EOB 711 "Claim denied. Client Does Not Have Hospice Lock-In". As a result, in order for the Hospice provider to obtain reimbursement for room and board charges paid to a nursing facility prior to the August 24, 2010 financial cycle recoupment, they must make arrangements with the facility for the repayment of these previously paid claims. Nursing facilities must in turn submit claims for room and board charges impacted by this issue directly to HP for payment.

HP would like to remind both Nursing Facility and Hospice providers respectively of their responsibility in checking client eligibility to ensure a Hospice lock-in is in place for the services rendered before submitting their facility charges to the Hospice and before submitting Hospice claims to HP.

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Hospice Providers

Prior Authorization for Hospice Services

All Prior Authorization (PA) requests for an inpatient level of care must be faxed to ***(860) 269-2135*** to ensure timely service authorization.

- Hospice providers should submit PA requests for an inpatient level of care using Revenue Center Code (RCC) 656.
- The start date of service for the PA is the sixth day of care.

Hospice care ***beyond twelve (12) months*** for ***Medicaid only clients requires PA***.

- Refer to www.ctdssmap.com > Publications > Chapter 9 for form completion.
- Fax PA form to ***(860) 269-2137*** or mail to **HP, Prior Authorization Unit, and P.O. Box 2943, Hartford, CT 06104** prior to the end of the twelve (12) month benefit period.

Hospice care ***beyond twelve (12) months*** for ***dually eligible*** (Medicare/Medicaid) ***clients requires the first page of the original election form*** be modified as follows:

- ***Strike through*** original effective date
- Indicate ***new effective date*** and note ***"Extension" next to the new date***.
- Fax to ***(860)424-5678*** as noted on the election form.

Hospice providers should refer to www.ctdssmap.com >publications >Chapter 9 for additional prior authorization information.

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Access Agency and CT Home Care Billing Providers

Prior Authorization Request Procedures

- ***All Initial Prior Authorization (PA) and Reauthorization Requests*** for CT Home Care Waiver and State Funded clients must be faxed to ***(860) 269-2137***. **NOTE**: Reauthorization requests may be mailed to HP, P. O. Box 2943, Hartford, CT 06104. PA requests faxed need not be mailed.
- ***Changes to an existing PA*** may be made by contacting the Connecticut Home Care Program via telephone at ***(860) 424-4906***.
- The PA fax line for the Connecticut Home Care Program is ***(860) 424-5313***.

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Home Health Agency Providers

Prior Authorization Request Procedures

- ***Initial Prior Authorization (PA) Requests*** made by a Home Health Agency must be faxed to ***(860) 269-2138***. This is a dedicated fax line to ensure your initial requests for service reach the Department of Social Services on time to avoid lost service authorization. *Providers should not* fax reauthorization requests to this line.
- ***Reauthorization Requests*** made by a Home Health Agency for an extension of an initial prior authorization must be faxed to ***(860)269-2137***. **NOTE**: These requests may be mailed to HP, P. O. Box 2943, Hartford, CT 06104. PA requests faxed need not be mailed.
- ***Increases in service or a change in plan of care to a previously authorized service*** must be requested via contacting the Department of Social Services via telephone at ***(860) 424-5192***.

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Home Health, Connecticut Home Care and Hospice Providers

Revision of Prior Authorization Request Form

The Prior Authorization (PA) Request Form has recently been revised. The form may be obtained from the www.ctdssmap.com Web site. From the Connecticut Medical Assistance Home page click Publications > Forms > Authorization/Certification Forms > Prior Authorization Request Form.

PLEASE NOTE the following:

- Providers may complete the PA form online to ensure clear legible requests, however, it cannot be saved. The form must be printed and faxed or mailed.
- When faxing your PA requests, ***each request must be faxed separately***. Faxing more than one PA together will cause a delay in processing your requests.
- If you are completing paper PA requests, be sure you have the most recent revision of the form, including the field by field instructions.
    - Hand written requests should be prepared in a legible manner.
- Incomplete or illegible requests or those submitted on outdated forms will be returned to your Agency.
    - A PA corrected by the provider should be resubmitted with the Return to Provider (RTP) letter indi cating why the PA was returned.

PA Form field changes include:

- ***Field 5a. & 5b. (Telephone Number/Contact Name & Fax Number)*** - Should contain the contact information of the individual completing the PA request, in the event additional information is required or the form needs to be returned. Please note, complete information in this field prevents delays in processing your request.
- ***Field 14. (Authorization Service Requested)***
    - ***Home Health Providers*** - Check Initial or Reauthorization only. Do not select any other category as it may delay your request.
    - ***Access Agency Care Managers or CT Home Care Billing Providers*** - Check Home Care Program for Elders (for Waiver or State Funded Clients)
    - ***Hospice Providers*** - Check Hospice
- ***Field 17. (Procedure Code/List)*** - Indicate procedure code, RCC or Code List. A code list should be used to avoid modifications to a PA whenever possible. See the code list categories and associated codes in each list at the bottom of the form instructions.
- ***Fax Numbers*** - Indicated at the bottom of the first/ front page of the form. Requests should be faxed based on the service requested in field 14. ***Note: Faxing to the incorrect number may cause delays in receiving your request which could result in a reduction or loss of in the service authorization.***
- ***Code List Key*** - Indicated at the bottom of the instruction page. ***PA requests for home health services must be authorized by code list instead of procedure code whenever it is possible that an interchangeable code in the list may be needed.***

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Appendix

Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
4/22/2011	Good Friday	Closed	Closed
5/30/2011	Memorial Day	Closed	Closed
7/4/2011	Independence Day	Closed	Closed
9/5/2011	Labor Day	Closed	Closed

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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.

PB11-15 New CT Behavioral Health Partnership
PB11-14 Physician Fee Schedule Changes to Procedure Codes J7302, 64611, 64613, and 64614
PB11-13 Important Changes to Web Claim Submission and Client Eligibility Verification
PB11-12 CMS National Correct Code Initiative(NCCI)
PB11-11 Performing Provider Enrollment for FQHCs
PB11-10 HIPAA 5010 Changes for Pharmacy Transtion to NCPDP Version D.0
PB11-09 HIPAA 5010 Implementation
PB11-08 Prior Authorization and Post Procedure Review Authorization Appeals Process
PB11-07 Dental Fee Schedule Changes for Quadrant Designation and for Unspecified Manually Priced Codes
PB11-06 HIPAA 5010 Changes to Eligibility Verification
PB11-05 Increase in Hospice Rates
PB11-04 Updated MEDS Fee Schedule and Reimbursement
PB11-03 Revisions to Policy Transmittal 2009-16 Disproportionate Share Hospital Audit and Reporting Protocol
PB11-02 Enhanced Care Clinic Changes in ECC Status Notification
PB11-01 Prior Authorization and Post Procedure Authorization for Payment Requirements
PB10-74 January 1, 2011 Changes to the Connecticut Medicaid Preferred Drug List
PB10-74 Billing Clarification for Brand Name Medications on the Preferred Drug List
PB10-72 Incorporation of January 2011 Healthcare Common Procedure Coding System (HCPCS) Changes
PB10-70 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (Medicaid, Medicaid LIA, ConnPACE, CADAP, HUSKY and Charter Oak Programs)
PB10-69 Additional Procedure Codes Requiring Prior Authorization
PB10-69 Physician Fee Schedule: Incorporation of January 2011 Healthcare Common Procedure Coding System (HCPCS) Changes
PB10-68 Clinic Fee Schedule: Incorporation of January 2011 Healthcare Common Procedure Coding System (HCPCS) Changes
PB10-67 Consolidated Laboratory Fee Schedule Update
PB10-66 Private Non-Medical Institution (PNMI) for the Rehabilitation of Adults Rates
PB10-65 Updated Transportation Fee Schedule
PB10-64 Medicaid Prescription Voucher for Individuals Released from Correctional Institutions or Through the Courts

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Appendix

Provider Bulletins (continued)

PB10-63 Expansion of Smoking Cessation Counseling for Pregnant Women
PB10-62 Behavioral Health Clinical Practice Improvement Initiatives
PB10-61 Post-payment Review of Behavioral Health Services
PB10-60 Modifier 26 and TC Restriction on Procedures
PB10-59 Group Therapy: Change in Maximum Group Size
PB10-58 Medicaid Low Income Adults (Medicaid LIA) Recoupment of Charter Oak Claims and Repayment as Medicaid

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