Connecticut Department of Social Services
Caring for Connecticut

October 2012
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- Person-Centered Medical Home (PCMH) Initiative
- Provider Data Verification Online Survey
- Electronic Health Records Incentive Payments
- Provider Training Available

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All Providers

Person-Centered Medical Home (PCMH) Initiative

The Department of Social Services (DSS) introduced a new initiative in 2012 for practices and clinics that demonstrates an innovative model of care that focuses on the person rather than the medical condition. Providers who practice a higher standard of person-centered primary care service delivery will qualify for a higher level of reimbursement for their primary care services from the Department. Practices will also be eligible for additional financial incentives based on performance measures.

A Person-Centered Medical Home provides person-centered, comprehensive and coordinated care. Care is organized around a person and led by a primary care provider who facilitates and coordinates a person's healthcare needs with other healthcare professionals. PCMHs improve access to care, improve efficiency of care, and improve coordination of care resulting in improved quality of care.

Administrative services to support PCMHs are provided by Community Health Network of Connecticut (CHNCT), the Department's medical Administrative Services Organization (ASO). PCMH application materials, including instructions on how to submit the applications, the reimbursement summary, and the primary care codes for which the PCMH Participation Fee Differential will be paid are all available on-line from the Department at www.huskyhealthct.org/providers/pcmh.html. Application questions can be directed to the Husky Health/Charter Oak Health Plan PCMH Program at 203-949-4194.

A policy transmittal PB11-84 was published in December of 2011 which outlined PCMH participation requirements, the PCMH application process, the Glide Path Option, recipient assignments and the enhanced reimbursement rates. The bulletin is available at www.huskyhealthct.org/providers/pcmh.html or it may be downloaded from the Connecticut Medical Assistance Program Web site at www.ctdssmap.com, under Information, Publications, and Bulletin search.

Providers seeking PCMH billing instructions should refer to the Connecticut Medical Assistance Program Web site at www.ctdssmap.com, under Information, Publications, Claims Processing Information, see PCMH Billing Instructions. PCMH billing questions may be directed to HP's Provider Assistance Center at 800-842-8440.

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Provider Data Verification Online Survey

The Department of Social Services is conducting an important online survey of Connecticut Medical Assistance Program (CMAP) providers. The purpose of the survey is to:

- Verify and update provider information
- Identify Primary Care Providers (PCPs)
- Identify provider specialties to a more specific level of detail

This information is necessary for the Department to be able to refer clients to appropriate specialty providers and to correctly identify and pay primary care providers effective January 2013. Much of the information provided will be used to populate the online provider search tool located on the HUSKY Health Web site, www.huskyhealth.com. The tool allows members and providers to search for participating CMAP providers. It will also be used to update your provider data on file with HP.

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Provider Data Verification Online Survey

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Verifying and updating provider information:
The survey is pre-populated with the most current information that you have provided to HP. Providers will have the ability to update some of the information when completing the survey. Some of the additional fields include: after hours availability, populations served, panel status (open/closed) and access to public transportation. The survey also allows you to provide additional alternate service locations.

Identifying provider specialties more specifically:
New physician specialties have been implemented. This will enable members to accurately locate provider services. The full list of the available specialties based on provider type is available in the drop-down menu in the survey. The list is also available on the Web site, www.ctdssmap.com. From the Home Page, under "Information", click on "Publications", scroll down to "Provider Enrollment/ Maintenance Forms", click on "Type/Specialty/Taxonomy Crosswalk". This will also allow DSS to implement the Affordable Care Act (ACA) reimbursement requirements in 2013.

Claims Impact:
Any address and/or provider specialty/taxonomy changes received through the online survey by the 20th of the month will be effective on the 1st of the following month.

Please note that changes made to the service location address and/or specialty/taxonomy will impact your claims. Please be sure the changes are reflected in your claim submission on the effective date as noted above.

Person-Centered Medical Home (PCMH) providers:
Please note that you must coordinate address changes with the HUSKY Health/Charter Oak Health Plan PCMH Program and HP in order to ensure your PCMH payments are not affected.

Identifying PCPs:
We must be able to identify PCPs to more accurately refer members to primary care and specialty services. A PCP is a general internist, family physician, general pediatrician, nurse practitioner, physician assistant or may be an obstetrician/gynecologist if he/she spends greater than 60% of their clinical time providing general primary care and not specialty care.

Listed below are the steps to access the online survey:

- Go to www.huskyhealth.com
- Click on "For Providers"
- Sign up or log into the secure portal
- Click on the Provider Survey

For assistance with the HUSKY Health Web portal or questions about how to complete the provider survey, please contact the HUSKY Health and Charter Oak Health Plan Web Support Team at 1-877-606-5172 during the hours of 9:00 a.m. to 4:00 p.m., Monday through Friday.

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Electronic Health Records Incentive Payments

Connecticut's Medicaid Electronic Health Records (EHR) Incentive Payment Program was launched on July 4th, 2011. Since launching, Eligible Professionals (EPs) and Eligible Hospitals (EHs) have been registering for and receiving incentive payments from Connecticut's Medicaid EHR Incentive Payment Program. CMS Web site has published the report "Payment Data by States by Program by Provider" for incentives paid through the end of July 2012. Connecticut has made Incentive Payments in the amount of:

Provider Type	Number of Providers	Amount Paid
Eligible Professionals	744	$15,285,845
Eligible Hospitals	16	$10,743,840
Total	760	$26,029,685

The EHR incentive program was established by the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act of 2009. The program aims to transform the nation's health care system and improve the quality, safety and efficiency of patient health care through the use of electronic health records by providing incentives for eligible hospitals (EHs) and eligible professionals (EPs), as hospitals and professional providers adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Wouldn't you like to be part of this movement that would transform the delivery of National Health Care? Would you like to learn more about participating in Connecticut's EHR Incentive Payment Program? Please visit the EHR Incentive Payment Program page from our Web site www.ctdssmap.com. You can also contact our EHR helpdesk Monday through Friday 8:00 AM to 5:00 PM (except holidays) toll free at 855-313-6638 or email your questions to ctmedicaid-ehr@hp.com.

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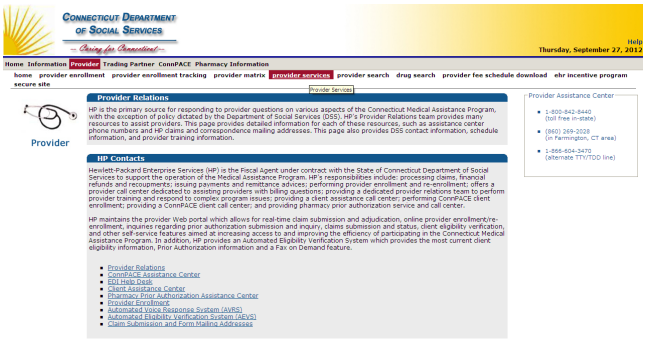
All Providers

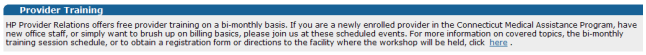
Provider Training Available

Did you know 'Free' training workshops are open to both providers and their office personnel?
To learn more start here: https://www.ctdssmap.com

Select <Provider> and click on <provider services>



Scroll down to <Provider Training> and click "here."



There are current and past training sessions available. You can sign up for current trainings or make copies of presentations from the past training sessions.

It's easy to register for an upcoming training session. Click on the training session of your choice <Registration Form/Directions>

Complete the online registration form. That's it! Questions regarding training may be directed to the HP Provider Assistance Center Mon. - Fri. 8:00 a.m. -5:00 p.m. (Except Holidays) Toll free at 1-800-842-8440 or write to HP, PO Box 2991, Hartford, CT 06104. You can also email your questions to CTDSSMAP-Provideremail@HP.com.

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Dental/Vision Providers

New Eyeglass/Vision and Denture Claim History Inquiry

The Web portal has been enhanced to offer vision and dental providers the ability to search a client's paid claim history to identify whether a client is eligible to receive eyeglasses or dentures in accordance with Department of Social Services' policy. To access this new tool, log into the secure Web portal, click on Claims and then click on Eyeglass Vision and Denture Claim History. Enter the client ID, Inquiry Type (Eyeglass Vision Services or Denture) and date you will be performing the service and then click search. The search results will return either the previous two (2) years of eyeglass/vision services or the previous seven (7) years of denture services the client received based on the inquiry type and date of service entered. Effective September 1st, 2012, the Provider Assistance Center will no longer perform these claim history inquiries. For further information on how to conduct claim history inquiry from the Web portal, please refer to provider bulletin PB 2012-36. Please note that verification of client claim history does not guarantee payment for services.

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Hospital Providers

National Drug Code (NDC) Requirement for Outpatient Hospital Claims Due to the Implementation of the Federal Deficit Reduction Act (DRA) of 2005

Effective for dates of service on or after January 1, 2012 a policy change was made for HUSKY A clients for RCCs 250-253, 258-259 and 634-637 that require claims to be submitted with the National Drug Code (NDC) and HCPCS code. This policy is now required on HUSKY A, C and D clients for outpatient hospital crossover and non-crossover claims. Claims for HUSKY B and Charter Oak clients do not need to be billed with NDC and HCPCS codes. If you bill the same RCC on multiple lines, the first detail will pay and any subsequent details will deny as duplicate. You will need to lump charges under the RCC code and submit it as one detail.

If you need assistance determining the correct corresponding HCPCS codes that goes with the NDC you are billing, please refer to the www.ctdssmap.com Web site by selecting "Provider" then "Drug Search". You can enter the NDC code you are billing for and it will provide you with a corresponding HCPCS code. The NDC, corresponding HCPCS code, correct NDC units and NDC units of measure must be submitted for the claim to be processed. Failure to bill appropriately will cause the claims to be re-couped due to the State not being able to collect rebate dollars.]

Please refer to provider bulletin 2010-35 "National Drug Codes (NDC) Required for Outpatient Hospital Claims due to the Implementation of the Federal Deficit Reduction Act (DRA) of 2005" or provider bulletin 2010-42 "Most Frequently Asked Questions related to the billing requirements necessary to support and comply with the implementation of the Deficit Reduction Act (DRA) of 2005" for complete instructions on claim submission requirements for submitting NDC required for outpatient hospital claims.

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MEDS Providers

Prior Authorization (PA) Requirements for Medical Equipment, Devices, and Supplies (MEDS) Dealers

A number of providers that have both Pharmacy and MEDS contracts with the Connecticut Medical Assistance Program have encountered some confusion on the PA process concerning Medical Equipment, Devices, and Supplies (MEDS) and Durable Medical Equipment (DME) items. Unlike pharmacy PAs for prescription medications which are required to be submitted to HP by the prescribing physician, MEDS/DME PA requests must be submitted to Community Health Network of Connecticut (CHNCT) for approval by the MEDS dealer.

To identify the procedure codes which require PA, providers should reference the appropriate Fee Schedule on the Connecticut Medical Assistance Web site: www.ctdssmap.com . From the home page, navigate to Provider > Provider Fee Schedule Download, accept the end user license agreement, and then click on the appropriate MEDS fee schedule link. Procedures that require PA are identified with a "Y" in the PA column.

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MEDS Providers

Prior Authorization (PA) Requirements for Medical Equipment, Devices, and Supplies (MEDS) Dealers

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MEDS dealers may submit their PA requests to CHNCT using any of the following methods:

- By calling 1-800-440-5071 (Monday through Friday from 8 a.m. to 7 p.m.)
- Faxing their request to (203) 265-3994. The PA Request Form can be found online at www.huskyhealth.com: click For Providers > Provider Bulletins and Updates > Outpatient Authorization Request Form
- Using CHNCT's Clear Coverage on line portal available at www.huskyhealth.com: click For Providers > Access Clear Coverage.

Any additional questions providers may have regarding the PA process should be directed to CHNCT at 1-800-440-5071.

There is one other MEDS PA issue that has caused a bit of confusion – PAs that are approved for quantities exceeding the limit listed on the MEDS-Medical/Surgical Supplies fee schedule. The fee schedule maximum quantities are enforced on a per-calendar-month basis and are based on the date of service on the claim. While the maximum monthly quantity of a procedure code may be exceeded with an approved authorization, any individual claim submitted must still adhere to the given limit. For example: let's say a provider receives a PA for procedure code A4927 (gloves, non-sterile, per 100), which normally has a maximum monthly quantity of 4 units, and that the approved PA has been authorized for 8 units per month. While the PA does allow the provider to dispense a total of 8 units in a single calendar month, because the individual claims must still adhere to the quantity limit imposed by the fee schedule (4 units), the provider would need to make two deliveries on two different dates of service, each for 4 units. Billing all 8 units on a single date of service will result in the billed units being cut back to the contract maximum.

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Hospice Providers

Hospice Updates

The Department of Social Services (DSS) has made a decision to increase the number of days allowed to submit any retroactive Hospice election transactions. Previously election effective dates could not be submitted if they were more than three (3) days prior to the current transaction date. Now, election effective dates can be submitted for up to seven (7) days prior to the current transaction date. Please note there have been no changes if the election is being submitted due to retroactive eligibility. Providers have seven (7) business days from the date the client was added to the eligibility file to submit their retroactive election transactions.

When submitting a discharge/revocation with the reason "Client no longer terminally ill…." the W 404 form must be faxed immediately to DSS at fax number (860) 424-5799 only if the client is eligible for Medicaid and not Medicare. If the client is dually eligible (i.e. eligible for both Medicaid and Medicare) DSS approval is not required. Do not send forms to DSS for dually eligible clients. They will be discarded.

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Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
10/8/2012	Columbus Day	Closed	Closed
11/12/2012	Veterans Day	Closed	Closed
11/22/2012	Thanksgiving	Closed	Closed
11/23/2012	Thanksgiving	Closed	Open
12/25/2012	Christmas	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.

PB12-42 New Medicaid (HUSKY) Spend-down Procedures

PB12-41 Client Notification Regarding the Use of A One-Time, 14-day Prior Authorization

PB12-40 National Correct Coding Initiative (NCCI) New Medicaid-Only Procedure to Procedure (PTP) edits relating to wheelchairs

PB12-39 Requirements for Payment of Services Provided by Independent Licensed Audiologists, Physical Therapists, Occupational Therapists and Speech Pathologists

PB12-38 Change of Dental Benefit Assignment by Dental Provider to Benefit Assignment by Client

PB12-37 Provider Data Verification Online Survey

PB12-36 Web Portal Claim History Inquiry

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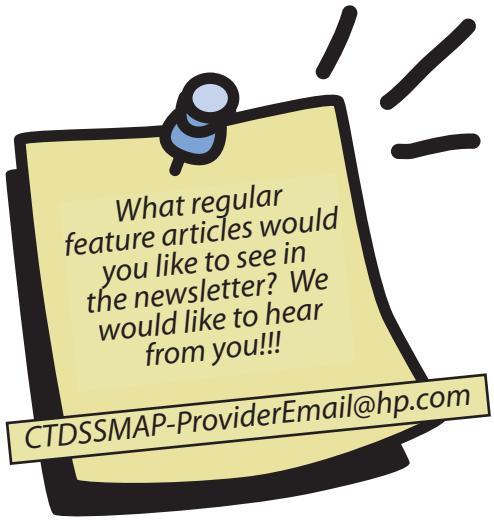

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