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 Update
New Connecticut Behavioral Health Partnership
Are You Ready for Electronic Health Records (EHR) Incentive Program?
CMS National Correct Coding Initiative (NCCI) Implementation

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HIPAA 5010 Implementation Update

DSS and HP continue to make progress in preparing for the new 5010 version of the HIPAA Transaction and Code Set Standards. The X12N 837 Companion Guides for electronic claim submission, including Institutional, Professional and Dental have recently been posted to the www.ctdssmap.com Web site. To access these documents, go to the Home Page and click on the HIPAA 5010 Important Message. Links to recently posted bulletins have also been added to this Important Message. Now is the time to contact your billing agency, software vendor or clearing house to ensure that they are upgrading their products to support HIPAA 5010. It is only seven months until CMS mandates the implementation of the new 5010 version on January 1, 2012. However, DSS will soon publish the dates when the existing 4010 format will no longer be accepted in the Connecticut Medical Assistance Program. Visit the HIPAA 5010 Important Message often to ensure that you are informed of these important dates.

Congratulations go out to Angie Bollard from Charlotte Hungerford Hospital who is the first provider to submit a successful 5010 claim transaction!

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New Connecticut Behavioral Health Partnership

The Department of Mental Health and Addiction Services (DMHAS) has been added to the Connecticut Behavioral Health Partnership (CT BHP) and the partnership has been expanded to include Medicaid clients not enrolled in the HUSKY benefit plan. The Medicaid clients not enrolled in the HUSKY benefit plan are those individuals typically referred to as 'Medicaid fee-for-service' (FFS), 'traditional', unmanaged' or those who are covered by the Medicaid for Low Income Adults (MLIA) program.

Beginning with dates of service April 1, 2011 and forward, the Administrative Services Organization (ASO), ValueOptions (VO), began to authorize and manage the behavioral health services for the expanded member populations.

Prior Authorization (PA) and claim submission information can be accessed from the www.ctdssmap.com Web site. From the Web site home page click on the Important Messages regarding the New Connecticut Behavioral Health Partnership. This will provide links to previously published bulletins as well as a link to the CT BHP Web site at www.ctbhp.com.

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Are You Ready for the Electronic Health Record (EHR) Incentive Program?

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. The Act authorizes states to provide for incentive payments to Medicaid providers for adopting, implementing, or upgrading certified EHR technology or the meaningful use of such technology.

Do you have questions about the EHR Incentive Program? Are you eligible to receive incentive payment under this program? Should you apply for Medicare or Medicaid incentive payment? What do you have to do to receive the incentive payment? How much can you receive in incentive payments? How do you apply for the EHR Incentive Program? DSS and HP have launched a separate Web page for the EHR Incentive Program from our current Web site www.ctdssmap.com. To access the Web page from the home page, select **EHR Incentive Program** under **Provider**. You will find helpful information as well as important links about the EHR Incentive Program from this Web page. We will keep this Web page updated with the latest information on the program.

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Changes to Web Eligibility Verification Response

If you have verified eligibility through your secure provider account on the www.ctdssmap.com Web site recently, you may have noticed a difference in the information received in the response. HIPAA 5010 changes which impact the Web eligibility response were promoted on March 9, 2011. The changes include:

- The addition of the covered individual's address
- The effective date of coverage for the month selected in your eligibility inquiry
- Service type codes that identify the services covered by the individual's benefit program(s). Covered Services are broken out by 'HP Services' and 'MCO Services' for individuals with HUSKY and Charter Oak coverage.

The possible types of service codes are listed below:

1-Medical	54-Long Term Care	AD-Occupational Therapy
4-DX X-Ray	56-Medically Related Transportation	AF-Speech Therapy
5-DX Lab	75-Prosthetic Device	AL-Vision (Optometry)
33-Chiropractic	82-Family Planning	DM-Durable Medical Equipment
35-Dental	86-Emergency Services	MH-Mental Health
42-Home Health Care	88-Pharmacy	PT-Physical Therapy
45-Hospice	93-Podiatry	RT-Residential Psychiatric Treatment
47-Hospital	98-Professional (Physician) Visit-Office	UC-Urgent Care

Please Note: These service type codes are established by CMS and do not include all covered services by the Connecticut Medical Assistance Program. For example, type code DM (Durable Medical Equipment) provides coverage for medical and surgical supplies, oxygen, prosthetic devices and hearing aids in addition to durable medical equipment. Providers should refer to their respective fee schedule(s) to identify the full range of covered services.

You will also notice some information previously received is no longer provided. In order to comply with CMS' mandate the following information can no longer be returned in the Web response:

- Other Payer's effective/end date of coverage – Both Medicare and Third Party Liability (TPL)
- Other Payer's Policy ID
- Other Payer's Policy Holder name
- Other Payer's coverage type(s)

No changes have been made to the response received in the Automated Voice Response System (AVRS) as a result of the HIPAA 5010 implementation as it is not an electronic transaction and therefore not impacted by this mandate. **The AVRS will continue to return TPL information in the client eligibility verification response**. Providers can access AVRS by dialing 1-800-842-8440 or locally to Farmington, CT at (860) 269-2028. Select option 1 for Self Service Options, enter the AVRS ID and PIN, and then select option 1 for Eligibility Verification. The provider may also contact the insurer to obtain policy related information.

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Medicare Covered Services

Do you know what it means when the eligibility verification response indicates "Medicare covered services only?" If this is the only coverage the individual is eligible for, the client only has Qualified Medicare Beneficiary (QMB) coverage. This means Medicare is the primary payer and DSS would be secondary. DSS will only cover the Medicare co-insurance and /or deductible due on Medicare paid claims under this benefit plan. Charges that are denied or not covered by Medicare will not be considered for payment under the QMB program. DSS will only consider Medicare primary denied claims when the client has multiple benefit plans and the second benefit plan does cover Medicare denials, i.e. "Medicare Covered Services" and "Medicaid Services".

Please note: Medicare Part D copays are not included in QMB coverage.

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Physicians, Nurse Practitioners, Dental, Optometrists, Podiatrist, Clinics and Hospitals

e-Prescribing Is on the Rise-Are You on Board?

Surescripts, the nation's leading e-Prescribing network, recently announced its 5th Annual SafeRx Awards, highlighting the top 10 states that have adopted the use of e-Prescribing. The SafeRX awards were created to raise awareness of how e-Prescribing improves patient safety with a more secure, accurate, and informed process for prescribing medications. Surescripts' annual Safe-Rx ranking measures the level of e-Prescribing activity in each state and the District of Columbia. Connecticut ranked 6th in the nation for 2009, moving up two spots from its' previous rank of 8th for 2008.

With e-Prescribing, the prescribing provider uses a computer or handheld device with software that enables him/her to: electronically access a patient's prescription benefit; with patient's consent, access their prescription history; and electronically route a prescription to a pharmacy of their choosing. All enrolled Medicaid providers with Surescripts certified e-Prescribing software have access to Connecticut Medical Assistance enrolled client information and can perform any of the following transactions:

- Client Eligibility
- Specific Program Formulary Information
- Client Medication History

The Medicare Improvements for Patients and Providers Act (MIPPA) went into effect January 1, 2009, and was an important driver of e-Prescribing growth throughout the year. Prescribers who use a qualified e-Prescribing system to prepare and send electronic prescriptions as defined by MIPPA are eligible to receive higher levels of reimbursement under Medicare through 2013. The Health Information Technology for Economic and Clinical Health (HITECH) Act is a key component of the American Recovery and Reinvestment Act of 2009 (ARRA). The main goal of the HITECH Act is to encourage the adoption of meaningful use of electronic medical records (EMRs) through incentive payments to physicians and hospitals. e-Prescribing is one of the core measures to meet meaningful use.

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CMS National Correct Coding Initiative (NCCI) Implementation

President Obama signed the Federal Patient Protection and Affordable Care Act (PPACA) into law in March 2010. The bill contains provisions that impact health care policy nationwide across both the public and private sectors. A provision of this law requires that state Medicaid agencies integrate the National Correct Coding Initiative (NCCI) payment edits into their claims payment systems by October 1, 2010. Exceptions are allowed without CMS prior approval through March 31, 2011.

Accordingly, the Connecticut Department of Social Services (DSS) has implemented the following NCCI edits:

1. **Medically Unlikely Edits (MUE)** or units-of–service edits define for each Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code the number of units of service beyond which the reported number of units of service is unlikely to be correct. The MUE edits were implemented effective 11/1/2010. This was conveyed via Provider Bulletin PB 2010-57
2. **Procedure code to procedure code edits** define pairs of HCPCS/CPT codes that should not be reported together on the same date of service for a variety of reasons and result in the denial of reimbursement for both procedures. Procedure code to procedure code edits were implemented effective 3/1/2011. This was conveyed via Provider Bulletin PB 2011-12.

DSS implemented the NCCI edits to comply with the PPACA law.

Three new Explanation of Benefit (EOB) Codes have been set up to notify providers if the procedure submitted on a claim fails the procedure code to procedure code edits. These EOB codes are:

- 5924 - CCI Greater and Lesser Procedures are Not Covered on Same Date of Service. This edit will set if both the greater and the lesser procedure codes are submitted on the same claim.
- 5925 - CCI Column 1 Code or Mutually Exclusive Code Was Billed on the Same Date as Previous Column 2 Code. This edit will set if the lesser procedure code has been paid and a claim with the greater procedure code is submitted for the same client for the same date of service.
- 5926 - CCI Column 2 Code Was Billed on the Same Date as Previous Column 1 or Mutually Exclusive Code. This edit will set if the greater code has been paid and a claim is submitted with the lesser code for the same client for the same date of service.

To ensure that the greater code is paid, HP has set up the following process for situations where the claim with the greater code is submitted after a lesser code has already been paid for the same client on the same date of service. The claim that sets edit 5925 will post and pay EOB 5925 on the greater code on the current claim and **a manual adjustment will be created to recoup the detail containing the lesser code that was previously paid**. The adjusted claim will post EOB code 5926 on the recouped detail. It may be possible to receive reimbursement for the recouped procedure code if a modifier can be used to bypass the procedure code to procedure code edit. For some code pairs, modifiers may be used to bypass procedure code to procedure code edits. This means that certain modifiers will allow both the greater and lesser codes to be paid when those services are performed on the same day for the same client. The list of modifiers allowed by Medicaid is identical to the list of modifiers allowed by Medicare. Chapter 8 of the Physician Provider Manual has a detailed list of modifiers that can be used. You can access this chapter from our Web site www.ctdssmap.com. From the Home page, click on Information, then Publications, scroll down the page to Provider Manuals section, select your provider type from the drop down menu for Chapter 8 and click "View Chapter 8".

Please be aware that the NCCI edits are designed to promote correct coding and to control improper coding that could lead to inappropriate payments. Visit the CMS Web site http://www.cms.gov/NationalCorrectCodInitEd/ for instructions on how to use NCCI, how to locate the NCCI Table Manual, how to look up procedure code to procedure code edits and the use of bypass modifiers.

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Are Your Pharmacy Claims Crossing Over From Medicare?

In order for crossover claims to process correctly, the National Provider Identifier (NPI) submitted on the Medicare claim must match the provider's NPI on file with the Connecticut Medical Assistance Program. Claims submitted to Medicare with any other NPI will not automatically cross over to Medicaid and cannot be processed without provider intervention. Additionally, providers who use the same NPI on different claim types such as pharmacy providers who also may have a DME business, must submit the appropriate taxonomy code to Medicare so that the claim will crossover and process with the intended provider account.

It is important to note that Medicare Part D pharmacy claims paid in the NCPDP format for Medicare Part B covered services such as nebulizer solutions, diabetic supplies, oral chemotherapy medications, and enteral products must also be processed as crossover claims. Medicare HMOs or Medicare Advantage plans allow Medicare Part B covered medications to be processed as a Medicare Part D covered service. Submitting the Medicare Part D co-pay in the NCPDP format will cause the claim to deny with Explanation of Benefit (EOB) code 2509 "Bill Medicare First." You will need to convert the claim from the NCPDP format to the CMS 1500 claim format and convert the NDC to the applicable Healthcare Common Procedure Coding (HCPC) code. The quickest way to convert and process your claim is through your provider secure Web account on the www.ctdssmap.com Web site. For complete billing instructions, please refer to Provider Bulletin PB09-36, "Clarification of Billing Requirements for Medications Covered by Medicare Part D and Medicare Part B" which walks you through the process. The bulletin may be accessed from the Home page by going to Information, then Publications, enter year 09, Number 36 in the Bulletin Search panel and click search.

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Acetaminophen in Prescription Products Will be Limited and Carry a Black Boxed Warning

Many prescription drug combinations, as well as over-the-counter products, contain significant amounts of acetaminophen which can lead to an increased risk of overdose and possible acute liver failure. On January 13, the FDA asked drug manufacturers to limit the amount of acetaminophen contained in all products to 325mg. All acetaminophen products will now have a black boxed warning about the risk of liver toxicity with overdose. Please educate customers receiving prescriptions for products that contain acetaminophen and encourage them to read Over the Counter (OTC) labels of combination products to prevent inadvertent overdoses.

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DME Providers

What Does Lst-15% Indicate on the Fee Schedule?

When looking at the DME fee schedule, do you know what the value of Max Fee Lst-15% means? Take a closer look and you'll see Lst-15% is only applicable when the Department of Social Services (DSS) allows the procedure code to be either repaired or modified. Procedure codes that allow for modification, repair, or rental are identified with multiple segments on the fee schedule to accommodate the applicable modifiers, as illustrated below:

1	K0001	STANDARD WHEELCHAIR		DEF	410.80	5/1/2007	12/31/2299	Y	1
2	K0001	STANDARD WHEELCHAIR	KA	DEF	Lst-15	5/1/2009	12/31/2299		1
3	K0001	STANDARD WHEELCHAIR	RB	DEF	Lst-15	5/1/2009	12/31/2299		1
4	K0001	STANDARD WHEELCHAIR	RR	DEF	41.08	5/1/2007	12/31/2299	Y	1

1 Purchase - Prior Authorization is required (3 months rental required prior to purchase per DSS policy)

2 Wheelchair add-on option/accessory is allowed - Prior Authorization is not required for the repair

3 Replacemet of a part of DME, Orthotic or Prosthetic item furnished as part of a repair is allowed Prior Authorization is not reuqired for the repair

4 Rental is allowed - Prior Authorization is required; if the item is needed after the third month of rental, the provider should submit an authorization request for the purchase with either the NR modifier to indicate the item was new or LL to indicate the item was used when rented and subsequently purchased

When the modification or repair of equipment is needed, new component(s) may be required to perform the modification/repair. Lst-15% represents the cost of the component(s) used. When the claim for this service is submitted, the billed amount should equal the sum of the published suggested retail price or Medicare's price for the components less 15%.

	03/01/11 MEDS-DME
Lst-15% in Max Fee column indicates to be priced at the lesser of list minus 15%	based on an appropriate published manufacturer's suggested retail price or Medicare price if available.

For example, if a wheelchair is repaired due to extensive use, it's plausible that new nuts, bolts, etc. may be required.

- The claim should be submitted for the procedure code and the modifiers RB (Replacement of a part of a DME item furnished as part of a repair) and NU (New). Submitting the claim with only the RB modifier will cause it to deny with Explanation of Benefit (EOB) code 4209, "Procedure/modifier combination is not active on file on date of service."
- If the suggested retail price for these items equaled $50.00 and no Medicare price was available, the claim's billed amount should not exceed $42.50.
- The billed amount should not be inflated to include the cost of labor. K0739 – "Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes," should be billed on a separate detail.

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Transportation Providers

Services Provided to Hospice Clients

Transportation providers are reminded that services provided to a hospice client which are unrelated to the client's terminal illness must be submitted to HP for processing with modifier GW in addition to the appropriate transportation modifier(s). Services that require Prior Authorization (PA) as indicated on the transportation fee schedule continue to require PA regardless of whether the GW modifier is used or not.

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Home Health and Access Agency Providers

New Behavioral Health Partnership Impact to Home Health and Access Agencies

Are you unsure of the impact that the New Connecticut Behavioral Health Partnership (CT BHP) will have on your Home Health Prior Authorizations (PAs)?

IMPORTANT: PA must be obtained from CT BHP for home health services when the reason for the service or primary diagnosis falls between diagnosis codes 291 and 316. Please be sure to read **Provider Bulletin PB 2011-21** for further information and direction in obtaining new authorizations or modifying existing authorizations for home health services falling in these diagnosis code ranges.

Is your request for PA outside of the behavioral health range of diagnosis codes 291 – 316?

PA requests with a primary diagnosis code outside of this range would be obtained from DSS. If, however, the primary reason for treating the client is within the 291-316 diagnosis code range and additional services outside of this range are required, PA would be obtained from CT BHP. Please be sure to read **Provider Bulletin PB 2011-21** to find out when, if at all, PA should be obtained from CT BHP.

Provider Bulletin PB 2011-21 can be found on the www.ctdssmap.com Web site home page. Under Important Messages, click the "New Behavioral Health Partnership" link. After opening, be sure to read the general program message then scroll down to the bulletin list. If you haven't read the Department of Social Services (DSS) Policy Transmittal on the new CT BHP, click on the PB11-15 link. For home health provider specific information, click on the PB11-21 link to review the changes impacting Home Health providers and Access Agencies who obtain Home Health PA when the primary reason for treatment or diagnosis is 291 – 316 or for secondary medical services when the primary reason for treatment is in the 291-316 range.

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Community Services, Mental Health Group Homes and Residential Treament Facility Providers

New Behavioral Health Partnership Impact to Community Services, Mental Health Group Homes and Residential Treatment Facility Providers

Are you unsure of how the new Connecticut Behavioral Health Partnership (CT BHP) will impact the services you provide to clients covered under the Connecticut Medical Assistance Program?

IMPORTANT: Log on to the www.ctdssmap.com Web site. On the home page, under "Important Messages", click the "New Behavioral Health Partnership" link. After opening the document, be sure to read the general program message then scroll down to the bulletin list. If you haven't read the Department of Social Services (DSS) Policy Transmittal on the new CT BHP, click on the **PB11-15** link. For Community Services, Mental Health Group Home and Psychiatric Residential Treatment Facility provider specific information, click on the **PB11-20** link to review how the new CT BHP will impact the clients you service and the prior authorization requirements.

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Hospice Providers

Hospice Reminders

Facility Charge Billing

Hospice providers are reminded that the policy for paying Nursing Homes is mandated by Sec. 1902 (a) (13) of the Social Security Act. As a result, Hospice providers are encouraged to review their contracts with the facilities they reimburse for room and board charges for clients under their hospice care. In order to accommodate the flow of reimbursement to both parties, providers should keep the following in mind when revising their contracts:

- Nursing Home room and board will not be paid to the Hospice or Nursing Home provider until there is a Nursing Home authorization segment on the client's eligibility file.
- Nursing Homes are paid up front by the client or representative for the client for monthly patient liability due.
- The full Patient Liability due for the month is taken from the first claim containing at least one detail for Nursing Home room and board received by HP.
    - This practice also applies to Nursing Homes when billing for reserve days for hospice clients receiving an inpatient level of care and for routine room and board for clients not covered under a hospice benefit.
    - Patient Liability in excess of the allowed amount of the claim is set up as an accounts receivable and deducted from the total payment amount on the same Remittance Advice (RA), if funds are available.
- Nursing Home providers are not allowed to bill for room and board charges in the current month until the first of the following month.

Election Forms

Hospice providers are reminded that Hospice Election forms must be faxed to the Department of Social Services (DSS) by the next business day following the client's election of the hospice benefit. Providers must fax both pages one and two of the election form, as page two contains the client's signature. Once faxed, providers are not required to mail in the original election form. Providers are reminded to review the election form for completion before faxing.

The following is a list of common errors on Hospice Election Forms received by DSS:

- Checking the incorrect Hospice Benefit Eligibility box, HM or HD. Please note that the Medicare and Medicare A (HD) box must be checked if the client has Part A Medicare. If the client has Part B only or is not covered under Medicare, the Medicaid Only (HM) box should be checked.
- Missing client's ID Number.
- Missing Hospice Provider Number.
- Effective date of hospice election (top of page one) not matching the date of client's signature (bottom of page two).

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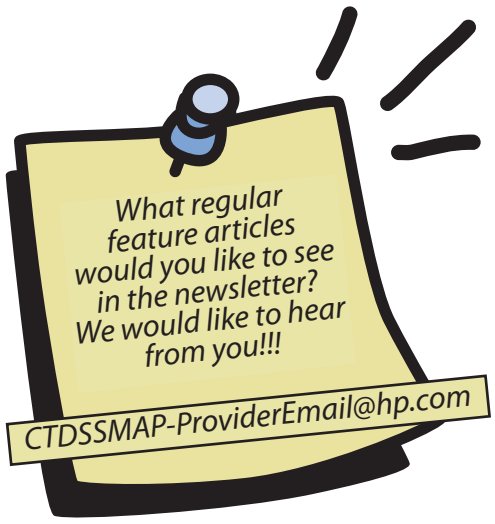

Home Health Providers

Top Home Health Provider Denial – 6229 "PA Required for More Than Two Nursing Visits Per Week"

Explanation of Benefit (EOB) 6229 will appear on your claim detail(s) when:

- You have already been paid for two nursing visits per week. A week is defined as Sunday through Saturday and may include any combination of the following codes (S9123, S9123TT, S9124, S9124TT, T1502, T1502TT, T1503 and T1503TT). **Solution**: Go to your secure Web account on the www.ctdssmap.com Web site and perform a claim inquiry to determine how many nursing units have been paid for each week of service billed. If you have exceeded two visits in a given week and have not requested PA, further visits in the week will not be paid until PA is obtained. If PA has been requested, check to be sure the PA is in place for the services and time frame billed. Modifications to requested units are documented in the external notes section of the PA. If there are no external notes as to why the PA was not approved as requested or other discrepancies exist, contact the source of your PA request (DSS or VO).
- If a PA is in place for a portion of the week and a claim is submitted for all services in the week, a detail within the span dates of service on the PA may deny. As a result, a detail may decrement the PA file, however, the system still counts each unit that pays up to the audit limit. **Solution**: Recoup the claim and resubmit dates of service outside of the PA start date within the same week first. To avoid this problem in the future, bill dates outside of the PA start date within the same week first on a separate claim or whenever possible, obtain PA from the first date in the week services will exceed the audit limit.

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Professional Providers, Behavioral Health Outpatient and Residential, Home Health, Hospice, Inpatient Psychiatric Hospital for Clients Under Age 21

Want to Help Your Prior Authorization (PA) Requests Process as Smoothly as Possible?

Did you know that faxing your Prior Authorization (PA) request to an incorrect fax number may cause a delay in its approval? Taking a moment to ensure the correct fax number has been selected can avoid this unnecessary delay from occurring. The illustration below identifies the various choices a provider has to choose from:

FAX to (860) 269 - 2138 for Home Health and Therapy (Initial Requests Only)

FAX to (860) 269 - 2137 for all other requests except for Urgent DME and Hospice

FAX to (860) 269 - 2135 for Urgent DME to facilitate the client's discharge from an institution or to prevent hospitalization or extensions of Hospice General Inpatient Care

If sending via USPS, send form to: HP, P.O. Box 2943, Hartford, CT 06104. Please do not mail if request has been faxed to HP.

Selecting an incorrect fax number may cause your request to be assigned to an unintended PA assignment type and delay its approval. Please choose wisely. A hasty decision may cause a delay to the approval of your request.

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Appendix

Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
5/30/2011	Memorial Day	Closed	Closed
7/4/2011	Independence Day	Closed	Closed
9/5/2011	Labor Day	Closed	Closed
10/10/2011	Columbus 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.

PB11-36 Definition of Medical Necessity
PB11-35 Present on Admission Indicator Change
PB11-34 Connecticut Medical Assistance Program Provider Satisfaction Survey
PB11-33 CMS National Correct Coding Initiative (NCCI) for Clinic Providers
PB11-32 Necessary Documentation of Physician Di rection in Office and Outpatient Settings
PB11-31 HIPAA 5010 Implementation of the 276/277 Claim Inquiry/Response Transaction
PB11-30 HIPAA 5010 Implementation Impact to CMS-1500 Paper Claim Submission
PB11-29 Medicaid for Low Income Adults (Medicaid LIA) Recoupment of Charter Oak Pharmacy Claims and Repayment as Medicaid
PB11-28 HIPAA 5010 Implementation of the 837 Institutional Electronic Claim Transaction
PB11-27 Medicaid for Low Income Adults (Medicaid LIA) Recoupment of Charter Oak Behavioral Health Claims and Repayment as Medicaid
PB11-26 HIPAA 5010 Implementation of the 837 Professional Electronic Claim Transaction
PB11-25 New Connecticut Behavioral Health Partnership Changes for Clinic Providers
PB11-24 April 1, 2011 Changes to the Connecticut Medicaid Preferred Drug List (PDL)
PB11-24 Reminder About the 5 day Emergency Supply
PB11-24 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)
PB11-24 Requirements for Coverage of Over-the-Counter Nutritional Supplements
PB11-23 HIPAA 5010 Implementation of the 837 Dental Electronic Claim Transaction
PB11-22 HIPAA 5010 Implementation of the 835 Health Care Payment/Advice
PB11-21 New Connecticut Behavioral Health Partnership Prior Authorization Changes
PB11-20 New Connecticut Behavioral Health Partnership Prior Authorization and Claim Submission Changes
PB11-19 New Connecticut Behavioral Health Partnership Changes - Behavioral Health Clinic
PB11-18 New Connecticut Behavioral Health Partnership - Hospitals, State Institutions, Physicians and Nurse Practitioners, Physician and Nurse Practitioner Groups
PB11-17 Physician Fee Schedule Changes to Procedure Codes J7300, M0064 and S2083
PB11-16 Changes to Eligibility Verification Due to the New Connecticut Behavioral Health Partnership

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