Connecticut Department of Social Services
Caring for Connecticut

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

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- HIPAA 5010 and NCPDP D.0 Compliance and Enforcement
- Enhancements to Online Provider Enrollment Wizard
- HUSKY Health Plan and Charter Oak Benefit Coverage Grids
- Are You Experiencing a High Number of Medicare Crossover Claim Denials After the Transition to HIPAA 5010?
- New Personal Care Assistant (PCA) Per Diem and Overnight Procedure Codes

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All Providers

HIPAA 5010 and NCPDP D.0 Compliance and Enforcement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities (including health plans, health care clearinghouses, and health care providers) adopt the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards when electronically conducting health care transactions such as claims, remittance, eligibility, and claims status requests and responses. Although the official mandatory compliance date for use of these new standards remains January 1, 2012, the Centers for Medicare and Medicaid Services (CMS) initiated enforcement with respect to any HIPAA covered entity that is non-compliant with the new standards on June 30, 2012. Any claims submitted in the non-supported transaction versions from July 1, 2012 forward will reject with Explanation of Benefits (EOB) code **617**, *Invalid claim version – submit in new HIPAA 5010 or NCPDP D.0*.

Providers may be encountering a number of new EOB codes related to this implementation. The following EOBs are currently setting on non-pharmacy claims submitted in the 5010 version. It is critical that providers encountering these EOBs make changes to their billing practices as soon as possible to avoid further claim denials. Check your remittance advice for the following EOBs and take action before it's too late!

618 "Billing provider address cannot contain P.O. Box"
619 "Zip code is not a valid 9 digit zip code"
620 "Service facility zip code is invalid"
621 "Billing provider entity type qualifier to provider type/specialty mismatch"
622 "Rendering provider type/specialty con flict with entity type qualifier"
1900 "Billing provider's taxonomy is invalid" (not a valid taxonomy)
1906 "Header billing provider's taxonomy is not valid" (not a taxonomy submitted via the provider's enrollment application)
1912 "Billing provider's taxonomy is missing"

Detailed information regarding the cause of these EOBs (and, more importantly, their respective resolutions) can be found in the Provider Manual Chapter 12 – *Claim Resolution Guide* available on our Web site www.ctdssmap.com. From the home page, navigate to *Information* > *Publications* and click on the link to Chapter 12 titled "Claim Resolution Guide" in the *Provider Manuals* section.

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New Provider Enrollment Address

Do you want your provider enrollment information sent to a different mailing address? The Department of Social services has enhanced interChange to allow you to identify a unique address to which all your enrollment/re-enrollment mail will be sent.
To update your enrollment address, perform the following steps:

- Log onto the main user's secure account at www.ctdssmap.com
- Click on Demographic Maintenance
- Click on Location Name Address (at bottom of the panel)
- Click on the Enrollment Address row
- Click on Maintain Address (to the right of the panel)
- Update the address
- Click on Save (at the bottom right of the panel)

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All Providers

Enhancements to Online Provider Enrollment Wizard

The online provider enrollment Wizard has been transformed into a much more efficient and user friendly application! Many of the evidentiary documentation requirements that providers were required to mail in to HP have been incorporated into the Wizard. For many new applicants, there will be no additional documentation to mail to HP. The online Wizard will capture everything that is needed to complete your application. Certain types of providers will continue to be required to submit additional documentation, especially those with special licensing requirements, however, documents such as the W-9, EFT form, Electronic Signature Addendum and the Deficit Reduction Act Affidavit will no longer be submitted to HP on paper. These forms are now a part of the new Wizard. The transformation is not yet complete. There is more work to be done, especially in the area of re-enrollment, but look out for these enhancements to the provider enrollment Wizard! Irene Benza, the Managed Care Credentialing Specialist from Charlotte Hungerford Hospital who used the new Wizard to enroll their hospital based physicians was quoted as saying "The enrollment process was so easy, I thought I did something wrong! Compared to other credentialing enrollments, HP's enrollment Wizard is the most efficient and easiest to use."

Important note: DSS will soon eliminate paper enrollment and re-enrollment applications for most providers in addition to paper address, Electronic Funds Transfer (EFT) and member of organization changes. Effective September 1, 2012, providers must submit initial enrollment applications via the online enrollment Wizard and update their demographic information via their secure provider Web account. Be on the lookout for an Important Message on the Home Page for more information.

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Non-Pharmacy and Non-Waiver Providers

HUSKY Health Plan and Charter Oak Benefit Coverage Grids

The Department of Social Services (DSS) and CHNCT have prepared benefit coverage grids that outline covered services for clients in the HUSKY Health Program and Charter Oak. Benefit information is broken down by provider type and the benefit plan. The contents provide a general summary of HUSKY Health and Charter Oak benefits. Providers can access the benefit coverage grids from the Providers page of the CHNCT website under "Benefits and Authorization". The link to the benefit coverage grids is listed below:

http://www.huskyhealthct.org/providers/benefits_authorizations.html

Providers should review these grids to determine covered services which may vary based on the client's benefit plan. The benefit coverage grids will be updated periodically.

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Professional Providers

Are You Experiencing a High Number of Medicare Crossover Claim Denials After the Transition to HIPAA 5010?

The previous HIPAA 4010 X12N 837 Professional electronic claim transactions had a restriction that prevented both the billing provider taxonomy and the rendering provider taxonomy from being submitted at the header of the claim. Claims in the 4010 version were submitted with either the billing provider taxonomy or the rendering provider taxonomy at the header of the claim. A majority of the providers submitted the rendering taxonomy at the header of the claim and it was utilized to process the claims. One of the crucial changes with HIPAA 5010 version of professional claims has been the ability to submit both the billing provider taxonomy and the rendering provider taxonomy at the header of the claim. The billing provider taxonomy is a requirement for Connecticut Medicaid claims processing. Have you noticed a high number of Medicare crossover claim denials since the transition to 5010? If so, the most likely cause for these denials is the lack of billing provider taxonomy at the header of these claims. The claims are still being submitted with only the rendering provider taxonomy. The billing provider taxonomy may not be required by Medicare, but it is essential for Medicaid claims processing. If you submit the billing provider taxonomy to Medicare, it will be crossed over to Medicaid. Please ensure with your vendor that the header billing provider taxonomy is not being stripped from your claims submitted to Medicare.

The provider NPI, Taxonomy Code and Zip Code+4 must be received in the appropriate loops. The loops are:

- 2000A Billing/Pay to Provider Specialty Information(Taxonomy)
- 2010AA Billing Provider (NPI and Zip Code+4)
- 2310B Rendering Provider

If your software or vendor cannot handle submitting both the billing and the rendering taxonomy at the header of the claim, you can keep the billing provider taxonomy at the header of the claim and drop the rendering provider information to the detail level in loop 2420A.

For more information, please refer to the companion guide available from our Web site:
https://www.ctdssmap.com/CTPortal/portals/0/StaticContent/Publications/companion_guide.pdf

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Connecticut Home Care Access Agencies, Connecticut Home Care PCA Providers

New Personal Care Assistant (PCA) Per Diem and Overnight Procedure Codes

Effective January 1, 2012, the Department of Social Services (DSS) established four new procedure codes for use when billing for PCA per diem and PCA overnight services. Providers should refer to the recent publication, Provider Bulletin PB 2012-35 for clarification on the use, billing and reimbursement of these codes when PCA per diem and PCA overnight services are provided. This bulletin may be found on the www.ctdssmap.com Web site under Publications >Bulletin Search >Year 2012>Number 35>Search.

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Free Standing Family Planning, Medical and Mental Health Clinics, Behavioral Health Clinicians, Physicians, Advanced Practice Registered Nurses (APRN) and Pharmacies

Expanding Coverage of Smoking Cessation Services

As of January 1, 2012, smoking cessation medications are covered for all clients enrolled with the HUSKY A, HUSKY C (formerly referred to as Medicaid fee-for-service), and HUSKY D (formerly referred to as Medicaid for Low Income Adults) programs. Pharmacy claims for smoking cessation agents no longer require a diagnosis of pregnancy in the NCPDP field 494-DO.

At the time of this newsletter's publication, the CT Medicaid Preferred Drug List identifies bupropion SR, Chantix, Nicorette (gum and lozenges), and generic nicotine gum, lozenges, and patches as the preferred smoking cessation agents that do not require prior authorization prior to being dispensed. Federal legend and Over-the-Counter (OTC) products are covered; all of which will require a prescription from the prescriber.

The expansion of coverage for smoking cessation counseling also took effect on January 1, 2012. Smoking cessation counseling is covered for all clients enrolled with the HUSKY A, C, and D programs when provided by an enrolled physician, APRN, behavioral health clinician (including psychologist, social worker, marital and family therapist, professional counselor and alcohol and drug counselor), medical clinic, mental health clinic, or family planning clinic. Professional claims for smoking cessation counseling require a tobacco-related primary diagnostic code; however, a secondary pregnancy-related diagnostic code is no longer required.

Please be aware that services provided by behavioral health clinicians, including smoking cessation counseling, are limited under the HUSKY C and HUSKY D programs to clients under the age of twenty-one (21). Also be aware that smoking cessation counseling continues to be covered **only for pregnant women enrolled with the HUSKY B and Charter Oak programs**. Claims for smoking cessation counseling for pregnant women enrolled in these plans will require a tobacco-related primary diagnostic code AND a pregnancy-related secondary diagnostic code in order for the claim to pay.

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HUSKY B and Charter Oak Client Restrictions

HUSKY B and Charter Oak clients are not eligible to receive all of the services listed in the MEDS fee schedules. Providers are reminded to review the exceptions prior to providing the service to HUSKY B or Charter Oak clients. Below is a listing of services which are excluded for these clients

CHARTER OAK SERVICES COVERED AND COST SHARE			
MEDS	Charter Oak	Charter Oak Limits	Charter Oak Coinsurance/CoPay
Durable Medical Equipment (DME) Refer to HUSKY C DME fee schedule as the base	**EXCLUDE:** Power Wheel Chairs K0802 – K0899		No Cost Share
Enteral/Parenteral Supplies Refer to HUSKY C Enteral/ Parental fee schedule as the base	Same as HUSKY C		No Cost Share
Hearing Aids/Prosthetic Eye Refer to HUSKY C Hearing Aid/ Prosthetic Eye fee schedule as the base	Same as HUSKY C		No Cost Share
Medical/Surgical Supplies	**INCLUDE:** Diabetic Supplies: A4230 – A4259 Diabetic Shoes: A5500 – A5501, A5503 – A5507, A5510, A5512, A5513 Infusion Supplies: A4221, K0552 Urinary Incontinence Supplies: A4310 – A4316, A4351 – A4352, A4356 – A4358, A5102 – A5105, A5112 – A5114 Ostomy Supplies: A4361 – A4434, A5051 – A5200 Compression Burn Garments: A6501 – A6513 Compression Stockings: A6530 – A6549 CPAP and Bi-PAP Supplies: A4604, A7027 – A7039, A7044 – A7046 **All other codes are Not Covered**	Follow HUSKY C for PA rules for A6501-A6513, A6530-A6541, A6544, A6545, and A6549	No Cost Share
Orthotics and Prosthetics Refer to HUSKY C Orthotic/Prosthetic fee schedule as the base	**EXCLUDE:** Foot Orthotics: L3000-L3207 Orthopedic Shoes: L3215-L3649		No Cost Share
Oxygen Refer to HUSKY C Oxygen fee schedule as the base			No Cost Share

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HUSKY B and Charter Oak Client Restrictions

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HUSKY B SERVICES COVERED AND COST SHARE			
MEDS	HUSKY B	HUSKY B Limits	HUSKY B Coinsurance/CoPay
Durable Medical Equipment (DME)	**EXCLUDE:** Power Wheel Chairs: K0802 – K0899		$0 CoPay
Enteral/Parenteral Supplies	Same as HUSKY C		$0 CoPay
Hearing Aids	HUSKY B does not cover hearing aids for children 13 years of age or older	No Coverage for HUSKY B clients 13 years of age and older	$1000 allowance limit for (V5030, V5040, V5050, V5060, V5120, V5130, V5140, V5170, V5180, V5210, V5220, V5256, V5257, V5260, V5261, V5274)
Medical/Surgical Supplies	**EXCLUDE:** Wigs: A9282 Incontinence Supplies: T4521 – T4543	Follow HUSKY C for PA rules for A6501-A6513, A6530-A6541, A6544, A6545, and A6549	$0 CoPay
Orthotics and Prosthetics	**EXCLUDE:** Foot Orthotics: L3000-L3207 Orthopedic Shoes: L3215-L3649		$0 CoPay
Oxygen Refer to HUSKY C Oxygen fee schedule as the base	Same as HUSKY C		$0 CoPay

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New for 2012 – Monthly PDL Updates

Is your Connecticut Medical Assistance Program Preferred Drug List (PDL) up to date? As of this past February, the PDL has been subject to monthly updates (rather than quarterly) in order to incorporate changes brought on by new generic products that have been made available between meetings of the Connecticut Pharmaceutical and Therapeutics Committee.

Over one dozen medications – including high volume items such as Effexor XR, Levaquin, and EpiPen – have been added to the PDL or had their status changed since the monthly PDL updates were implemented. Have you been keeping informed of these updates? It is important for prescribers and pharmacies to keep up-to-date with the most recent PDL information to ensure that patients receive their medication in the most timely and efficient manner possible.

To assist in the timely dispensing of prescribed medications, HP would like to remind providers of the automatic emergency overrides that are available.

- A one-time prior authorization (PA) for a 14-day supply of medication is available for clients that are newly prescribed a non-preferred drug. This override is available for all medications that are subject to the PDL and allows ample time for the physician to be contacted and a standard prior authorization to be obtained before the two-week supply is exhausted.
    - The pharmacist can dispense a one-time fourteen day temporary supply by entering all 9s in the Prior Authorization Number Submitted field, NCPDP 462-EV, and a numeric value of "1" in the Prior Authorization Type field, NCPDP 461-EU.
- An additional override is available for clients that have been treated with non-preferred mental health medications within the last year. The pharmacist can attest to this within the pharmacy claim submission which will auto-generate an approved non-preferred drug authorization with an effective period of one year; no physician intervention is required.
    - The pharmacist should enter all 8s in the Prior Authorization Number Submitted field, NCPDP 462-EV, and a numeric value of "1" in the Prior Authorization Type field, NCPDP 461-EU, to generate the year-long mental health medication approval.

Further information regarding the Connecticut Medical Assistance Program PDL, PA process and requirements, and various other claims and policy related topics is available on www.ctdssmap.com. The *Pharmacy Prior Authorization Form* can be obtained by navigating to the *Information* > *Publications* page, locating the *Forms* > *Authorization/Certification Forms* section, and clicking the appropriate link; it is also available on the *Pharmacy Information* page within the *Pharmacy Program Publications* section. The PDL is available in two formats (with preferred medications either sorted by therapeutic class or in alphabetical order); both are available on the *Pharmacy Information* page in the *Preferred Drug List Information* section. You may also access these documents using the following links:

- Pharmacy Prior Authorization Form
- Current Medicaid Preferred Drug List
- Alphabetized Preferred Drug List

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Physicians, Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), Independent Radiology Centers, Outpatient Hospitals

Important Changes to Radiology Services

For dates of service June 1, 2012 and forward, non-emergent advanced imaging and nuclear cardiology services require prior authorization when performed in an outpatient setting.

To manage outpatient advanced imaging and nuclear cardiology procedures for clients enrolled in the HUSKY Health Program and Charter Oak Health Plan, Community Health Network of Connecticut, Inc. (CHNCT), the Department's medical administrative service organization, with assistance from Care to Care (CtC), a radiology benefit management company are processing prior authorization requests. The HUSKY Health Program and Charter Oak Health Plan's radiology management program will include the requirement of authorization for advanced imaging – CT, CTA, MRI, MRA, PET, PET/CT and nuclear cardiology studies – using comprehensive clinical criteria available on the CtC website at: www.caretocare.com. Please refer to provider bulletin 2012-18, Important Changes to Radiology Services found on www.ctdssmap.com for complete instructions on billing and obtaining prior authorization.

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Physician, Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife, Optometrist, Podiatrist, Clinic and Outpatient Hospital Providers

Participating Labelers for Physician Administered Drugs

Connecticut Medicaid, by statute, will only pay for a drug procedure billed with a National Drug Code (NDC) when the pharmaceutical manufacturer of that drug is a participating labeler with the Centers for Medicare and Medicaid Services (CMS). A 'participating labeler' is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each State a rebate for products reimbursed by Medicaid Programs. A labeler is identified by the first 5 digits of the NDC.

Providers can determine whether an NDC is rebateable or not by utilizing the "Drug Search" functionality under "Provider" from our Web site. Be aware that even though the drug may be rebateable, not all labelers participate in all client benefit plans. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code to the list of participating labelers maintained on the Connecticut Medicaid Web site at www.ctdssmap.com. From the home page of our Web site, click on the "Pharmacy Information" page, then on the client's benefit plan under the "Drug Manufacturer Rebate Lists" posted in the "Pharmacy Program Publications" panel.

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New Physician Specialties for the Connecticut Medical Assistance Program

The Department of Social Services (DSS) has implemented new Physician specialties including new Pediatric and new Advanced Practice Registered Nurse (APRN) specialties for the Connecticut Medical Assistance Program. The new specialty numbers, specialty descriptions and taxonomies for the new specialties are available on the Type/Specialty/Taxonomy Crosswalk.

The Type/Specialty/Taxonomy Crosswalk can be accessed from the Connecticut Medical Assistance Program Web site, www.ctdssmap.com. From this Web site go to "Information" then to "Publications", scroll down to "Provider Enrollment/Maintenance Forms", and then click on "Type/Specialty/Taxonomy Crosswalk".

Providers may begin to enroll immediately with these new specialties. Providers may choose to update their existing specialty and taxonomy to one of the new specialty/taxonomy combinations. To do so providers will not be required to complete a new re-enrollment application. Providers are required to submit a letter on letterhead to the HP Provider Enrollment Unit at P.O. Box 5007, Hartford, CT 06104. This letter must include the provider's NPI, AVRS ID, the new specialty/taxonomy combination and the effective date of their new specialty/taxonomy combination.

Providers enrolled as a group such as Internal Medicine which includes different specialties may choose to form a separate group for each of their specialties at this time or wait until the time of their re-enrollment. However, providers are not required to form a new group for each specialty. DSS will allow providers within an Internal Medicine group to continue to have different specialties. Specialties that are reimbursed at a unique rate i.e., pediatric services and obstetrical services cannot enroll other specialties in their group. When forming a new group with one of the new specialty/taxonomy combinations, the group must complete an enrollment application and follow the normal enrollment process.

When the taxonomy is updated, it is extremely important to submit all claims with the new taxonomy to avoid claim processing issues. The taxonomy is often used to identify the correct AVRS ID to process the claim.

Providers are reminded that taxonomies they submit to the HP Provider Enrollment Unit must be the same taxonomies registered with the National Provider Plan and Enumeration System (NPPES). If the taxonomies are not the same, the provider will receive a Return to Provider (RTP) Letter informing the provider they must register their taxonomies with the National Provider Identifier (NPI) Registry.

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Physicians, Advance Practice Registered Nurses (APRN), Certified Nurse Midwives and Dentists

Eligible Providers: Do You Think You Missed the Boat on Applying for the Electronic Health Records (EHR) Incentive Payments? Think Again!

Connecticut launched the EHR Incentive Payment Program in July 2011. Under the Program, CT Medicaid reimburses Eligible Providers (EPs) for adopting, implementing or upgrading to a certified EHR system in the first payment year and for demonstrating meaningful use of the EHR technology in subsequent years of participation in the Program. Providers eligible to participate in the Connecticut Medicaid EHR Incentive Payments Program are Physicians, Advance Practice Registered Nurses, Certified Nurse Midwives, Dentists and Physician Assistants who furnish services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant enrolled in the Connecticut Medical Assistance Program. The incentive payments are spread over 6 years. If you did not apply for the EHR Incentive Payments in 2011, don't fret. You still have some time left to apply for the incentive payments. In fact, 2016 is the absolute last year that you can apply to participate in Connecticut Medicaid's EHR Incentive Program. See below for a timetable of Incentive Payments:

	Medicaid EPs who begin meaningful use of certified EHR technology in--					
Calendar Year	2011	2012	2013	2014	2015	2016
2011	$21,250	----------	----------	----------	----------	----------
2012	$8,500	$21,250	----------	----------	----------	----------
2013	$8,500	$8,500	$21,250	----------	----------	----------
2014	$8,500	$8,500	$8,500	$21,250	----------	----------
2015	$8,500	$8,500	$8,500	$8,500	$21,250	----------
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	----------	$8,500	$8,500	$8,500	$8,500	$8,500
2018	----------	----------	$8,500	$8,500	$8,500	$8,500
2019	----------	----------	----------	$8,500	$8,500	$8,500
2020	----------	----------	----------	----------	$8,500	$8,500
2021	----------	----------	----------	----------	----------	$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

The table depicts payments for EPs who meet 30% Medicaid patient volume. Pediatricians can however qualify for EHR Incentive Payments with a lower Medicaid patient volume. Pediatricians can qualify with 20% Medicaid patient volume, but their payment will be reduced by two thirds of the amount listed in the table above.

Want more information? Visit the EHR Payment Program page from our Web site. Or call our EHR Incentive Payment Program helpline at 1-855-313-6638, or email us at ctmedicaid-ehr@hp.com.

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Physician, Advanced Practice Registered Nurse, Certified Nurse Midwife

Current Audit Updates Relating to Global Period Surgical Procedure Reimbursement

The Department of Social Services (DSS) has updated current audits related to the global periods for surgical procedures reimbursed under the Connecticut Medical Assistance Program (CTMAP) in order to be more consistent with guidance established by the Centers for Medicare and Medicaid Services (CMS) and current medical practice. All surgical procedure codes which do not have a global period and which have global period of 0, as defined by CMS, have been removed from the following audits:

Audit 5261 "Surgical procedures and established patient office visit not covered on the same date of service."

Audit 5262 "Payment for surgical procedure includes follow up hospital care."

Audit 5265 "Hospital visits not covered following surgery."

Surgical procedure codes with a global period of 0 can now be reimbursed with Evaluation and Management (E/M) services provided on the same date of service.

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Trading Partners

When to Update Your Trading Partner Agreement to Add Covered Providers or New Transactions

HP receives numerous Trading Partner Agreement (TPA) updates via fax. We encourage trading partners to discontinue faxing the data and begin using the web portal for crucial updates. Existing Trading Partners are only required to update their TPA to add a provider who will receive 835 Remittance Advice or 820 Premium Payment transactions. Trading Partners are not required to update their TPA for a provider who will be submitting an existing 837 Electronic Claim, 270, Eligibility Request or 276, Claim Status Transaction, when the provider will not be receiving an 835 Remittance Advice.

Trading Partners using the secure web portal to update their TPA benefit by controlling their updates in real time, such as adding electronic transactions they wish to submit to the Connecticut Medical Assistance Program, in addition to adding or end dating providers to control their receipt of the 835 Remittance Advice reports.

Trading Partners can access the web portal by logging on to the https://www.ctdssmap.com Web site using their Trading Partner user ID and password. From the home page click on Trading partner> Trading Partner Enrollment Profile, then click next until reaching the page of the form applicable to your updates. While on the secure Web site, Trading Partners should also ensure their information on page 2 is accurate. Trading Partners should add new transactions they wish to submit on Page 3 and add or end date providers on page 4 to control receipt of their 835 Remittance Advice or 830 Premium Payment transaction. Trading Partners will find the web portal easy to use and the most cost effective and efficient method to update required data in an efficient and timely manner.

Trading Partners with questions or a need for assistance should contact the HP EDI Help Desk at 1-800-688-0503.

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Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
9/3/2012	Labor Day	Closed	Closed
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

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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.

PB12-35 New Personal Care Agency (PCA) Per Diem and PCA Overnight Procedure Codes
PB12-34 Changes to Prior Authorization Process for Outpatient Surgery
PB12-33 New MAC Pricing Inquiry Worksheet
PB12-33 Reminder About the 5 day Emergency Supply
PB12-33 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)
PB12-33 July 1, 2012 Changes to the Connecticut Medicaid Preferred Drug List (PDL)
PB12-32 Hospital Inpatient Services
PB12-31 Change in Procedures for Brand Medically Necessary Pharmacy Prior Authorizations
PB12-30 Changes to Prior Authorization Process for Laboratory Procedures and Outpatient Surgery
PB12-29 Authorization Portal for Requesting MEDS
PB12-28 Changes to Authorization Process and New Authorization Portal for Requesting Rehabilitation Therapy
PB12-27 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health, Charter Oak, ConnPACE, and CADAP Programs)
PB12-26 Consolidated Laboratory Fee Schedule Update
PB12-25 Payment Error Rate Measurement (PERM) Program Audit Requests
PB12-24 Changes to Request Process for Vision Care that Require Prior Authorization
PB12-23 Update Concerning Prior Authorization (PA) Requests for Repairs to Prosthetics
PB12-22 Other Provider Preventable Conditions (OPPCs) Reporting Requirements
PB12-21 Connecticut Medical Assistance Program Provider Satisfaction Survey
PB12-20 Other Provider Preventable Conditions (OPPCs) Reporting Requirements
PB12-19 Behavioral Health Clinician Fee Schedule Update
PB12-18 Important Changes to Radiology Services
PB12-17 Clarification of Billing Requirements for Medications Covered by Medicare Part D and Medicare Part B Including Additional Third Party Insurance
PB12-16 Authorization Portal for Medical Admissions
PB12-15 Authorization Portal for Requesting Medical Home Care Services
PB12-14 Authorization Portal for Requesting Outpatient Hospital Rehabilitation Therapy
PB12-13 Physician Fee Schedule Updates: Updated fees for Psychiatric and Selected Adult Medical Services
PB12-12 Department of Social Services Prescriber and Pharmacy Surveys
PB12-11 Physician Signature on the CMS-485, Home Health Certification and Plan of Care

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Provider Bulletins

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PB12-10 Enhanced Editing of Prescribing Provider NPI Numbers
PB12-09 Updated MEDS Fee Schedule and Reimbursement
PB12-08 Delay in the Enforcement of Enrolling Certain Types of Performing Providers
PB12-07 New Family Planning Coverage Group: Family Planning Services - Limited Benefit
PB12-06 Presumptive Eligibility Certification and Guarantee of Payment Form, W-538
PB12-05 New Physician Specialties for the Connecticut Medical Assistance Program
PB12-04 Behavioral Health Clinician Coverage for Individuals Under Age 21 in Fee-For-Service Medicaid (HUSKY C) and Medicaid for Low Income Adults (HUSKY D)
PB12-03 Instructions for Mass Load of Performing Providers
PB12-02 Billing for Addiction-Related Laboratory Services
PB12-02 Direct Billing of Clients for Medicaid Covered Addiction Services
PB12-01 Transition from Revenue Center Code 513 to More Precise Coding for Hospital Outpatient Psychiatric Services

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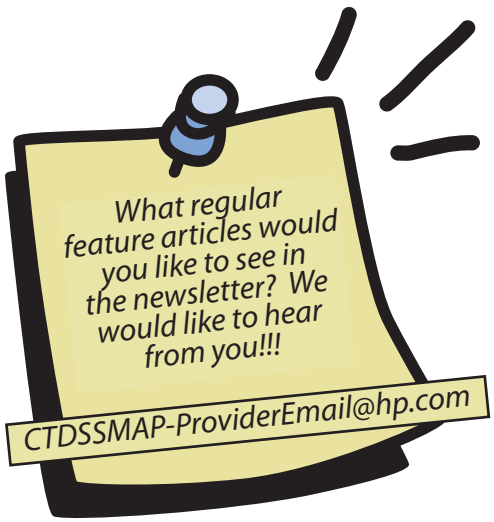

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