April 2016
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- Important Changes to the Personal Care Attendant (PCA) Waiver Program Impacting Prior Authorization for Home Health Services!
- Important Dates to Remember for the CT Medicaid EHR Incentive Program
- Update to the Consent to Sterilization Form
- Hospitalization Bed Reserve Guidelines

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PCA and Home Health Agencies

Important Changes to the Personal Care Attendant (PCA) Waiver Program Impacting Prior Authorization for Home Health Services!

Effective February 25, 2016, all home health services, regardless of standard benefit, provided to PCA Waiver clients must be authorized by the Access Agency managing their care. As a result all home health services must be on the PCA client's care plan in order for Home Health Agencies to be reimbursed for the services provided.

Services Exceeding Standard Benefit:

PCA Waiver clients whose services currently exceed standard benefit that have been authorized by Community Health Network (CHN) have been end dated. A new authorization will be established by the Access Agency upon service confirmation with the Home Health Agency.

PCA Waiver clients whose services currently exceed standard benefit that have been authorized by Beacon Heath Options will be linked to the client's Care Plan by the Access Agency.

Services At or Below Standard Benefit:

Home Health Agencies currently servicing clients at or below standard benefit **must contact the Access Agency managing the clients care as soon as possible** for confirmation of service **so an applicable service authorization can be added to the client's care plan**. Home Health Services that are not on the client's Care Plan will not be paid.

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Professional Providers

Important Dates to Remember for the CT Medicaid EHR Incentive Program

On October 16, 2015, CMS published the Final Rule for Stage 3 and Modifications to Meaningful Use (MU) in 2015 through 2017 and the 2015 Edition Health IT Certification Criteria. The final rule sets new criteria for Eligible Professionals (EPs) and Eligible Hospitals (EHs) to meet in order to successfully participate in the EHR Incentive Program. The CMS Final Rule took effect on December 15, 2015.

Providers who wished to attest to the previous MU standards for the EHR Incentive Program had until December 14, 2015 to submit their attestation in MAPIR (Medical Assistance Provider Incentives Repository). As of December 15, 2015, providers must now attest to the new requirements as stated in the Final Rule. However, MAPIR will be unable to accept MU attestations on or after December 15, 2015 until the system has been modified to accommodate the new CMS Final Rule. At this time, the modification is estimated to be completed by May 30, 2016. Once the MAPIR enhancements are completed, providers will be able to submit MU attestations for the 2015 and 2016 program years. The deadline for eligible hospitals to attest in program year 2015 has been extended from December 31, 2015 to March 30, 2016.

Any eligible provider MU applications submitted between December 15, 2015 and May 30, 2016 will be aborted and the providers will be asked to start their attestations after MAPIR has been upgraded. This means all information entered into the attestation will be deleted and the provider will have to reenter the information into an entirely new attestation.

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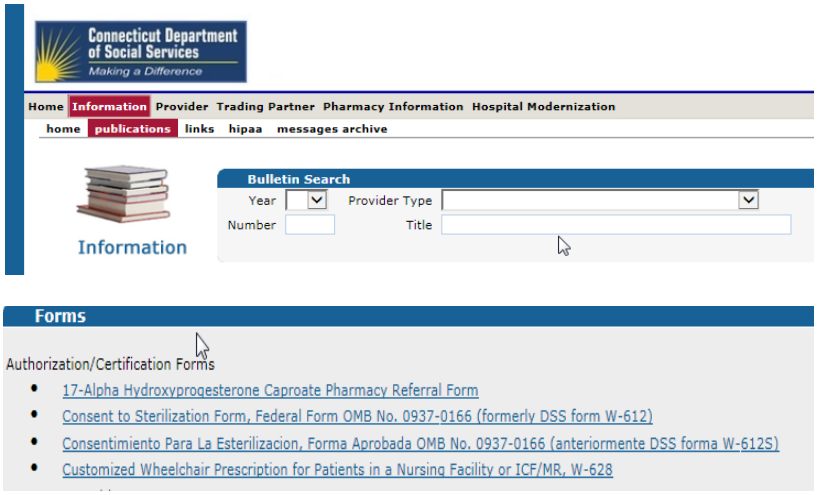
Professional Providers

Update to the Consent to Sterilization Form

Hewlett Packard Enterprise has just posted an updated version of the Consent to Sterilization form in both English and Spanish. These forms can be found on the www.ctdssmap.com Web site under the Information tab. From the Information tab, click on "Publications", then scroll down to the Forms section.



Double click on the appropriate version to access the form.

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Nursing Facility Providers

Hospitalization Bed Reserve Guidelines

Are you aware of the requirements for billing hospital leave bed reserve days? If you answered no, the following information will provide you with guidance to ensure that bed reserve days are billed appropriately. As described in section 19a-537 of the Connecticut General Statutes, a nursing facility may bill up to 15 days for bed reserve for a patient who is discharged from the facility due to hospitalization, unless the nursing facility documents that it has objective information from the hospital confirming that the resident will not return to the nursing home within fifteen days of the hospital admission (including the day of hospitalization).

Days 1 - 7:

The Department of Social Services (DSS) shall reimburse the nursing facility for reserving the bed of a resident who is hospitalized for a maximum of seven (7) days, including the admission date of hospitalization, if the nursing facility documents that on such date and the following criteria are met:

(A) There is a vacancy rate of not more than three (3) beds or three (3) percent of licensed capacity, whichever is greater; **and** (B) contact has been made to the hospital and the hospital failed to provide objective information confirming that the person would be unable to return to the nursing facility within fifteen days of the date of hospitalization.

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Nursing Facility Providers

Hospitalization Bed Reserve Guidelines

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Days 8 – 15:

DSS shall reimburse the nursing facility for a maximum of eight (8) additional days if the following criteria are met:

> (A) On the seventh day of the person's hospital stay, the nursing facility has a vacancy rate that is not more than three (3) beds or three (3) percent of licensed capacity, whichever is greater; **and** (B) contact has been made to the hospital for an update on the person's status and the nursing facility documents such contact in the person's file and the information obtained through the contact does not indicate that the person will be unable to return to the nursing facility within fifteen days of hospitalization.

As a reminder, nursing facilities **only** have two (2) opportunities to determine whether or not a bed reserve is billable; nursing facilities must check on day one (1) for days 1 – 7 and day seven (7) for days 8 – 15 as noted above. When calculating the number of vacancies, nursing facilities should not round up. Nursing facilities are strongly encouraged to follow these policy guidelines so that monies aren't recovered during future audits.

When billing for billable/covered bed reserve days, providers must use revenue center code (RCC) 185 - "Inpatient Hospital Reserve" along with occurrence code 42 and "Date of Discharge". When billing for non-billable/non-covered bed reserve days, providers must use RCC 189 – "Non-covered reserve". For complete provider specific claim submission instructions, please visit our Web site at www.ctdssmap.com. From the home page, click on "Information, then "Publications", scroll down to "Provider Manuals" then select Nursing Facilities, ICF/IID and Chronic Disease Hospital from the Chapter 8 drop down menu.

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Outpatient Hospital Providers

Addendum B

Effective on or after July 1, 2016, the Department of Social Services (DSS) will be moving to an Outpatient Prospective Payment System (OPPS). Hospitals will be utilizing CMAP's Addendum B to determine method of payment for all hospital outpatient services. The hospitals current reimbursement system based solely on Revenue Center Codes (RCC) will no longer be utilized.

The Department will maintain a file, CMAP version of "Addendum B," that lists each Healthcare Common Procedure Code (HCPC) and Current Procedural Terminology (CPT) code and the status indicators that are assigned to each code. The payment type field identifies if a HCPC or CPT code is a payable code and determines the method of payment. There are additional columns for status indicator, relative weight, Ambulatory Payment Classification (APC) group, and the CT Fee Schedule. The link for CMAP Addendum B can be found on the www.ctdssmap.com Web site on the "Hospital Modernization" page under "Important Messages - Connecticut Hospital Modernization". The document is in an Excel format that hospitals can utilize to find if the HCPCS and CPT codes are paid based on fixed fee, fee schedule or APC assignment. The payment type field guides the platform for each codes payment status. DSS will maintain CMAP Addendum B and review and update. Also, background information for CMAP Addendum B can be found on the Connecticut Department of Social Services Reimbursement Modernization web site at http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256.

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Outpatient Hospital Providers

Outpatient Hospital Modernization
Hospital Based Practitioners – Outpatient Services

The Department of Social Services (DSS) will be moving ahead with the Outpatient Prospective Payment System (OPPS). Claims submitted on or after July 1, 2016 will start to process with the APC grouper software; however, most outpatient professional fees will be reimbursed outside of APC. Hospitals will need to create and enroll at least one practitioner group in the Connecticut Medical Assistance Program (CMAP) in order to bill for outpatient professional services separately. If the hospital has already enrolled as a practitioner group for inpatient professional services as referenced in Provider Bulletin 2014-68 "Hospital Based Practitioners – Inpatient Services", the hospital will not have to enroll a separate group for the same specialty in order to bill for outpatient services on or after July 1 ,2016. Please refer to Bulletin 2016-06 "Hospital Based Practitioners – Outpatient Services" on our Web site under "Information", "Publications" for more detailed instructions on enrolling/re-enrolling for hospital outpatient professional services. This will ensure that the hospitals will be reimbursed outside of the OPPS for their outpatient professional fees for dates of service July 1, 2016 and forward. Please submit your practitioner group enrollments no later than May 31, 2016 to meet the July 1, 2016 enrollment deadline. Hospitals must enroll their practitioner group(s) using the Hewlett Packard Enterprise Provider Enrollment Wizard located on the Web site www.ctdssmap.com.

Hospitals will also need to make sure their hospital based practitioners (performing providers) are enrolled in CMAP under a participation type of individual provider or as Employed/Contracted by an Organization. Please note that new enrollments for outpatient professional claims will not be active until implementation on July 1, 2016.

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Behavioral Health Providers

Billing Modifiers

Reminder: Behavioral health clinicians must bill using modifiers identifying the provider on all claims based on their provider type and specialty.

Provider Type/Specialty	Modifier
Licensed Clinical Social Worker (LCSW)	AJ
Licensed Marital and Family Therapists (LFMT)	HO
Licensed Professional Counselors (LPC)	HO
Licensed Alcohol and Drug Counselors (LADC)	HO
Certified Alcohol and Drug Counselors (CADC)	HO
Psychologists	N/A

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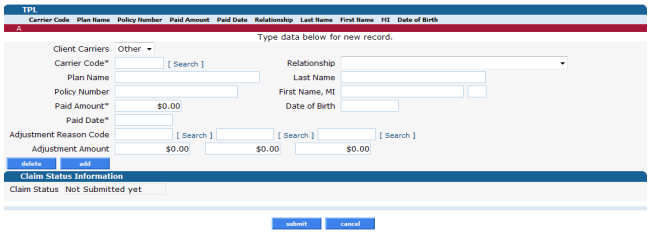
Billing Claims with Other Insurance (OI) Primary

The Connecticut Medical Assistance Program (CMAP) is the payer of last resort for all covered services. Therefore, if a HUSKY client has applicable Other Insurance (OI) coverage, the benefits of these policies must be fully exhausted prior to claim submission to CMAP. We have come across situations where dental providers bill Medicaid primary claims electronically, but drop Medicaid secondary claims on paper. This may be because their software is not equipped to submit claims with OI information. Did you know you can easily bill these claims via the secure Web portal? Submitting claims via the Web portal is much more efficient and expedient than submitting on paper.

Once you log on to your secure Web portal account, you will click on Dental Claims, and fill out the information relevant to the client and the service(s) provided. Towards the bottom of the page is the TPL (Third Party Liability) section. Before you can enter the OI information, you will have to click on the "Add" button within this panel to enable the fields.



The following are the required fields needed for filling out the OI information:

- Carrier Code – 3-digit carrier code identifying the OI carrier. If the client's eligibility via the Automated Eligibility Verification System (AEVS) shows OI information, the carrier code will be available via the drop down field titled "Client Carriers". If you have information that the client has OI but the AEVS doesn't return this information, you can enter the 3-digit carrier code in the field titled "Carrier Code". To assist providers in locating the carrier code, there is a "Search" link next to this field. If no match is found, you can enter 999 as the carrier code.
- Paid Amount – Enter amount paid by the other insurance; if denied, enter zero.
- Paid Date – Enter the date the other insurance paid or denied the claim.
- Adjustment Reason Code, if OI denied.

Once this information is entered, you can submit the claim and receive the immediate outcome of your claim. You are not required to submit the OI Explanation of Benefit (EOB) to support your claim; however, you should retain the documentation in case of an audit. For step by step instructions you can refer to Chapter 11 of the Provider Manual titled "Other Insurance and Medicare Billing Guides". The chapter can be accessed from the www.ctdssmap.com Web site; click on "Information" under "Publications", scroll down to the Provider Manuals section, select "Dental Other Insurance/Medicare Billing Guide" from the drop down option for Chapter 11.

We hope you will utilize the Web claims functionality to submit your OI claims to us and find out for yourself how efficient it is. We are sure you will never go back to submitting these claims on paper!

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Are Your Claims Denying For Medically Unlikely Edits?

The list of Durable Medical Equipment (DME) codes subject to the Medically Unlikely Edits (MUEs) continues to grow with every quarter as part of the regular review process and many Medical Equipment, Devices, and Supplies (MEDS) Dealers are experiencing higher rates of claim denials as a result.

If you are familiar with Explanation of Benefit (EOB) code 0770 "MUE UNITS EXCEEDED," chances are you have not changed your billing practices and MUEs are impacting your claims.

What can you do to limit the number of MUE related denials?

- Know the DME codes subject to MUEs (not all services are subject to MUEs!)
  - Quarterly Medicaid MUE additions, deletions, and revisions are published by CMS and can be accessed by clicking the following link: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

  MARK YOUR CALENDAR. New MUEs are available at the start of every quarter. The 1st quarter begins on January 1st; the 2nd quarter begins on April 1st; the 3rd quarter begins on July 1st; and the 4th quarter begins on October 1st of each year.
- The MUEs for provider claims for durable medical equipment are available under the "Medicaid NCCI Edit Files" by clicking on the following icon:

MUEs for provider claims for durable medical equipment 

- Report the correct day supply for products/supplies dispensed.
  - MUEs prevent payment for inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code represents the maximum number of units of service reportable by the same provider for the same patient on the same date of service.
- For example, when dispensing a 30 day supply of A4313 (Catheter w/bag 3-way) the provider must enter the "From" and "To" dates in MM/DD/YY format where the "From" date represents the dispense/delivery date and the "To" date represents the last day of supply utilization or the date before the next delivery is made. Failure to report the "To" date of service is equivalent to reporting a day supply of 1 and will cause the claim to deny if the units billed exceed the MUE for the given HCPCS/CPT. In this instance, A4313 has an assigned MUE value of 2:

HCPCS/CPT Code	DME Supplier Services MUE Values	MUE Rationale
A4312	2	NCCI Policy
A4313	2	NCCI Policy
A4314	2	NCCI Policy
A4315	2	NCCI Policy
A4316	2	NCCI Policy

- MUE are "per day" edits and take precedence over the maximum quantity allowed displayed on the MEDS fee schedule. Please be aware that the quantities displayed in the quantity column on the MEDS fee schedule are the maximum allowed units per month. The quantities billed must always be medically necessary and ordered by a prescribing practitioner. Additional units requested per month will require prior authorization but **will not** override the daily MUE.

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All Providers

What Should You Know About Referring Medicaid Beneficiaries To Other Providers?

The Affordable Care Act (ACA) requires that all providers who render services to Medicaid beneficiaries be enrolled in the Connecticut Medical Assistance Program (CMAP).

The Department of Social Services (DSS) allows providers to enroll as:

- An individual or performer with the applicable provider type and specialty. This type of enrollment allows providers to receive payment from CMAP for services rendered either directly or indirectly via their billing group; or
- An Ordering, Prescribing, Referring (OPR) provider. A provider in this capacity does not have billing capability and will not receive reimbursement for services rendered.

Enrollment requirements ensure that all services, orders, prescriptions, or referrals for items, or services for Medicaid beneficiaries, originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. This may include a laboratory receiving an order for a lab test for a Medicaid beneficiary or a pharmacy receiving a prescription for a specialty drug.

When referring a Medicaid beneficiary to another provider, ordering labs or sending prescription orders, the issuing provider should make sure that the provider receiving the referral, order, or prescription is also enrolled in CMAP.

For example, if a provider draws blood and then sends the bloodwork to a laboratory to be processed, it is the provider's responsibility to ensure the laboratory receiving the bloodwork is enrolled with CMAP. If the laboratory the provider works with is not enrolled with CMAP, the provider should send the bloodwork to a CMAP enrolled lab.

This criteria applies even if the patient has other coverage such as commercial insurance or Medicare.

Referring Medicaid recipients to non-enrolled providers results in undue financial burden to the Medicaid beneficiary and potential balance billing for services that may otherwise be covered under the Medicaid program.

As a reminder, it goes against the Medicaid guidelines to balance bill a Medicaid beneficiary, their family or their power of attorney for any unpaid balance once Medicaid has paid what it allows under the Medicaid fee schedule.

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Appendix

Holiday Schedule

Date	Holiday	HPE	CT Department of Social Services
3/25/16	Good Friday	Closed	Closed
5/30/16	Memorial Day	Closed	Closed
7/4/16	Fourth of July	Closed	Closed

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Appendix

Provider Bulletins

Below is a listing of Provider Bulletins that have recently been posted to www.ctdssmap.com. To see the complete messages, please visit the Web site. All Provider Bulletins can be found by going to the Information -> Publications tab.

PB16-07 Updated MEDS Fee Schedule Changes
PB16-06 Hospital Based Practitioners - Outpatient Services
PB16-05 Changes in the Home Health Prior Authorization Process for PCA Waiver Clients
PB16-04 Change in Timeframe for Requesting Authorization for Retroactive Eligibility
PB16-03 Hospice Payment Changes
PB16-02 Billing for Partial Payment for Behavioral Health Intermediate Levels of Care
PB16-01 Important PCA Waiver Provider Enrollment and Claim Submission Changes for Agency Providers of Adult Family Living and Support Broker Services Under the PCA Waiver Program
PB15-104 2016 Dental Fee Schedule HIPAA Compliant Update
PB15-103 New Prior Authorization Form for PCSK9 Inhibitors
PB15-102 New Coverage Guidelines for CPT Code V2025 Deluxe Frames
PB15-101 2016 Clinic Fee Schedules HIPAA Compliant Update
PB15-100 2016 Independent Audiology and Speech and Language Pathology Fee Schedule HIPAA Compliant Update
PB15-99 2016 Independent Radiology Fee Schedule HIPAA Compliant Update
PB15-98 School Based Child Health Provider Enrollment/Re-Enrollment on the Web
PB15-97 Removal and Addition of Select Services
PB15-97 2016 HIPAA Compliant Update
PB15-97 Place of Service Codes
PB15-97 Establishing Maxfees for Select Services
PB15-96 Consolidated Laboratory Fee Schedule Update

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