



**Connecticut Department
of Social Services**

Caring for Connecticut

July 2010

Connecticut Medical Assistance Program

<http://www.ctdssmap.com>

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

SAGA to Medicaid LIA
HIPAA 5010 Update
OTC Changes
Husky B Co-pays
PCCM Expansion

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State Administered General Assistance Program Becomes Medicaid for Low Income Adults

Effective April 1, 2010, the State Administered General Assistance Program (SAGA) is being discontinued and individuals formerly covered under SAGA will be covered under Medicaid. This change is pursuant to section 2001 (a)(40)(A) of the Patient Protection and Affordable Care Act (also known as national health care reform). These adults will now have access to the fee-for-service Medicaid health care benefit package. This will have a positive impact on the state budget as the state will now receive federal reimbursement

for what were previously all state expenditures.

The program name for this new Medicaid population is "Medicaid for Low Income Adults", which will be referred to as "Medicaid L-I-A." Client notification mailings were initiated to the Medicaid LIA population on July 1, 2010.

The following provides important information on the changes in the management of the new Medicaid LIA program.

Managed Care Coverage Discontinued

Community Health Network of CT (CHNCT) will discontinue managing the medical component of the SAGA medical program effective July 1, 2010.

In order for the state to receive Federal reimbursement for services provided to this client population retroactive to April 1, 2010, CHNCT will be recouping claims from providers that were paid on behalf of SAGA clients for dates of service on or after April 1, 2010. Beginning July 1, 2010, providers should submit claims for dates of service on or after April 1, 2010 to HP Enterprise Services for processing under the Medicaid program. Authorizations provided by CHNCT for dates of service April 1, 2010 through June 30, 2010 will be honored. Claims will be paid in accordance with Medicaid fee-for-service reimbursement rules.

Effective with dates of service July 1, 2010 and forward, providers should follow the existing Medicaid fee-for-service prior authoriza-

tion protocol for services formally managed by CHNCT, for Medicaid LIA clients.

Behavioral Health Management Changing

Advanced Behavioral Health (ABH), under contract with the Department of Mental Health and Addiction Services (DMHAS), will continue to operate as their Administrative Services Organization for non-Medicaid covered services. However, ABH will discontinue managing the Medicaid covered behavioral health component of the SAGA medical program effective July 1, 2010.

The Department of Social Services (DSS) will assume responsibility for behavioral health services as the clients are now covered under Medicaid. Qualidigm will authorize inpatient general acute care hospital admissions in the same manner as they do for Medicaid.

In order for the state to receive Federal reimbursement for services provided to this client population retroactive to April 1, 2010,

ABH will be recouping claims from providers that were paid on behalf of SAGA clients. Providers should submit those claims with dates of service on or after April 1, 2010 to HP Enterprise Services for processing under the Medicaid program beginning July 1, 2010, except for claims for inpatient, partial hospital and adult day treatment. Claims for behavioral health inpatient, partial hospital and adult day treatment may be submitted beginning July 15, 2010. Authorizations provided by ABH will be honored and if necessary modified to reflect the correct coding for Medicaid payment. Claims will be paid in accordance with fee-for-service Medicaid claims submission requirements, procedure codes and reimbursement rules. In some instances the claim submitted to HP will need to be modified to reflect different billing rules under Medicaid and GA BHP:

- Federally Qualified Health Centers must submit claims with the encounter code as well as the procedure code;
- Hospitals must submit claims using Revenue Center Codes (not CPT codes);

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Behavioral Health Management Changing (cont)

- Ambulatory Detoxification services must be billed using code H0014;
- Freestanding clinic providers that are not federally designated Community Mental Health Centers must submit claims for day treatment services using code H2013 for both mental health and substance abuse programs.

Methadone providers will retain SAGA payments received from ABH for claims with dates of service between March 28, 2010 and April 3, 2010.

Department of Mental Health and Addiction Services Continues Coverage

DMHAS will continue to provide prior authorization and payment for residential substance abuse treatment, Institution for Mental Disease (IMD) services for clients aged 21-64 and Recovery Supports Program services for Medicaid LIA clients. Providers should call ABH at 1-800-606-3677.

Non-Emergency Medical Transportation

Medicaid LIA clients can now receive non-emergency medical transportation to a Medicaid covered appointment. Coordinated Transportation Solutions (CTS) will coordinate all rides to scheduled appointments. Medicaid LIA clients should contact CTS at 1-877-423-6794.

Client Eligibility Information

Eligibility verification responses for this population will be "Client eligible for Medicaid L-I-A" for dates of service inquiries of April 1, 2010 forward. For dates of service inquiries prior to April 1, 2010 you will continue to receive "Client eligible for State Administered General Assistance Program."

Remittance Advice

Until changes can be made to provider remittance advices, Medicaid LIA claims will continue to report as fund payer "S". Any such claims for DOS on or after April 1, 2010 are actually Medicaid LIA claims. In the near future Medicaid LIA claims will report under a new fund payer designation.

Behavioral Health Prior Authorization Changes

The Department is temporarily suspending the requirement for prior authorization of intensive outpatient program services and of outpatient psychotherapy services in excess of 13 visits within a 90 day span. This change affects ALL Medicaid clients. Authorization of the following codes is suspended effective April 1, 2010:

Mental Health Clinics	90804-90815, 90846, 90847, 90853, 90857, H0015, S9480
Rehabilitation Clinics	90804-90909, 90846, 90847, 90853, 90857
Medical Clinics	90804-90908, 90846, 90847, 90853
Independent Practitioners	90804-90819, 90821-90824, 90826-90829, 90846, 90847, 90853, 90857
General Hospitals	
• Outpatient Clinic Visit	513
• Intensive outpatient Programs	905 and 906
Psychiatric Hospitals	
• Individual Therapy	914
• Group Therapy	915
• Family Therapy	916
• Intensive outpatient programs	905 and 906

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Medicaid Electronic Health Record Incentive Program

The Centers for Medicare & Medicaid Services (CMS) announced on July 16, 2010 the final rule to implement the provisions of the American Recovery and Reinvestment Act of 2009 (Recovery Act) that provide incentive payments for the adoption and meaningful use of certified electronic health record (EHR) technology. The Medicare EHR incentive program will provide incentive payments to eligible professional (EPs), eligible hospitals, and critical access hospitals (CAHs) that are meaningful users of certified EHRs. ***The Medicaid EHR incentive program will provide incentive payments to EPs and eligible hospitals for efforts to adopt, implement, upgrade, or meaningfully use certified EHR technology.***

Medicaid eligible practitioners are physicians (primarily doctors of medicine and doctors of osteopathy), dentists, nurse practitioners, certified nurse midwives and physician assistants practicing in a Federally Qualified health center led by a physician assistant. Eligible practitioners cannot be hospital based. Eligible practitioners must meet minimum patient volume thresholds of 30 percent; for pediatricians, it is 20 percent.

Medicaid eligible hospitals that can participate are acute care hospitals (which include cancer and critical access hospitals) and children's hospitals. An acute care hospital is a primary health care facility where the average length of patient stay is 25 days

or fewer. Hospitals with a CMS Certification Number that has the last four digits in the series 0001 – 0879 or 1300 – 1399 are eligible. Acute care hospitals also must have 10 percent Medicaid patient volume in order to participate. Children's hospitals only need to have CMS Certification Numbers in the 3300 – 3399 series to participate.

Eligible practitioners must choose between the Medicare or Medicaid incentive program. Medicaid eligible practitioners can receive up to \$63,750; pediatricians will receive two-thirds of the maximum amount; and hospital payments are based on a formula outlined in the statute.

The Department of Social Services has begun the planning process to develop and implement the incentive program with our fiscal agent, HP Enterprise Services. DSS is also working with the Regional Extension Center, eHealth Connecticut, and the Department of Public Health in identifying and assisting providers in implementing certified EHR technology and achieving meaningful use.

Additional information will be forthcoming. The link to the final rule is: <http://www.cms.gov/EHRIncentivePrograms>.

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HIPAA Update: 5010 Transactions, NCPDP and ICD-10 Coming Soon

New standards have been named for HIPAA transactions and one of the key coding systems for medical billing purposes. Providers should read the information below for background and key dates from the new regulations.

Providers are reminded that the following changes will occur to comply with HIPAA:

- ASC X12N Version 5010 will replace Version 4010/4010A. **All covered entities must be compliant with 5010 on January 1, 2012.**
- National Council for Prescription Drug Programs (NCPDP) Version D.0 will replace NCPDP Version 5.1. **All covered entities must be compliant with D.0 on January 1, 2012.**
- ICD-10-CM and ICD-10PCS codes replace the current ICD-9-CM, Volumes 1 and 2 and the ICD-9-CM Volume 3 for diagnosis and procedure codes, respectively. **All covered entities must be compliant with ICD-10 on October 1, 2013.**

Version 5010 Format

Health plans, health care clearinghouses and certain health care providers must use the 5010 format when conducting electronic transactions, including:

- Claims (professional, institutional and dental) – 837P, 837I and 837D
- Claims status requests and responses – 276/277
- Remittance Advices – 835
- Eligibility requests and responses – 278
- Enrollment and disenrollment in a health plan – 834
- Premium payments – 820

Version 5010 accommodates the ICD-10 code sets and has an earlier compliance date than ICD-10 in order to ensure adequate testing time for the industry. Additional information regarding ICD-10 will be published separately.



NCPDP Version D.0

NCPDP Version D.0 will replace the current version of the NCPDP Version 5.1 for standard covered entities,

including health plans, health care clearinghouses and certain health care providers. Covered entities must use Version D.0 for pharmacy and supplier transactions, including:

- Claims
- Eligibility requests and responses
- Referral certification and authorization
- Coordination of Benefits

All covered entities must be fully compliant with 5010/NCPDP Version D.0 on January 1, 2012, and ICD-10 on October 1, 2013.

Resources

Additional information will be published in upcoming Provider Bulletins and on the www.ctdssmap.com Web site. In addition, HP's Provider Assistance Call Center will be available to answer questions at 1-800-842-8440 or locally to Farmington at (860) 269-2028.

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Provider Electronic Solutions Upgrade

An update to the CT HP Provider Electronic Solutions software is now available. Version 3.76 includes the Present on Admission (POA) indicator for hospital inpatient admissions on or after 4/1/2010. All Provider Electronic Solutions software users should install this update.

If you currently have the Provider Electronic Solutions software on your pc or network, there is no need to do a "Full" install of the application. Providers can upgrade to version 3.76 via the Web or by logging into Provider Electronic Solutions. Please follow the instructions for the "Provider Electronic Solutions Upgrade" feature

on our Web site www.ctdssmap.com, under Trading Partner and then EDI (Electronic Data Interchange) for instructions via the Web or Provider Electronic Solutions software.

To upgrade to version 3.76 you must be working with version 3.75. To determine which version you are on, you will need to log into Provider Electronic Solutions software. A pop-up box will display with the version you are signed into. If you do not see this pop-up box once you have logged in, you will need to choose the Help tab and select About and this will provide you with the version you are currently using.

If you are working on version 3.74, you must upgrade to 3.75 before upgrading to version 3.76. Once the upgrade to version 3.75 is completed you can upgrade to version 3.76. If you do not upgrade each version in order, you risk losing data that maybe unrecoverable.

Please remember that if you have workstations sharing a database, the database location (typical install) must be upgraded first, and then each workstation must be upgraded, and must be upgraded one version at a time, in the proper order.

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New Provider Manual Chapter 11

Other Insurance and Medicare Billing Guides

Medicaid is the payer of last resort. All other resources must be billed prior to submitting a claim to the Connecticut Medical Assistance Program. Other Insurance/Medicare Billing Guides are now available to assist providers with instructions for billing secondary and/or tertiary claims. To access these guides from the Home page, go to Information -> Publica-

tions -> scroll down to Provider Manuals, Chapter 11. From the drop down box, providers will select the appropriate chapter based on claim type: Institutional, Professional, or Dental.

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2009 Provider Satisfaction Survey Results are in!

Thank you to all the providers who participated in the 2009 Connecticut Medical Assistance Program Provider Satisfaction Survey. While many providers responded favorably and reported an increased satisfaction rate in a number of areas, HP and the Department of Social Services (DSS) are jointly working to identify and address any concerns that were shared in the survey.

Please continue to watch for announcements on the www.ctdssmap.com Web site, banner page messages and articles in future newsletters as we continue enhancing services to better serve our provider community.

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New Provider Workshop Registration

HP and the Department of Social Services (DSS) are pleased to introduce a new on-line method of registering for workshops which will allow providers to self-enroll for upcoming provider training sessions. It's quick, paperless, and immediately lets providers know they have enrolled in the workshop with a confirmation message.

All scheduled provider workshop invitations will continue to be posted to the Web site at www.ctdssmap.com. From the Home page, go to Information -> Publications -> Forms and scroll down to the Provider Workshop Invitation Forms section. Select the appropriate invitation by clicking on the link. This will open the invitation document. The new registration option will be listed under the "How to Register for a Workshop" section on page 2 of the invitation.

HOW TO REGISTER FOR A WORKSHOP

- **Via Web Site** - <http://www.surveymonkey.com/s/> <Workshop time and date listed here>. Multiple attendees from the same provider must register separately. Limit 2 attendees per provider. Required fields are provider name, phone number and attendee name, all other fields are optional.
- **Via Email** – Send your response via email to CTDSSMAP-ProviderEmail@hp.com. Please indicate "Provider Workshop Registration" in the subject line.
- **Via Telephone** – [\(860\) 255-3810 ext. 16588](tel:(860)255-3810). To register for the workshop, please leave a message on this voice mailbox.

To utilize the self-registration feature, click on the workshop link and enter the required information in the fields listed. Once the registration information has been entered, click on the "Register Now" button on the bottom of the page and a registration confirmation message will display.

If the number of attendees has exceeded the training site capacity and we are unable to accept your registration, a message will display requesting that another date or time be selected or to check the Web site for future workshop sessions.

Please note that we request a maximum of two attendees per provider be registered for a given workshop in order to accommodate as many providers as possible. Each attendee must be registered individually on the Web site. Only one name should be entered in the "Name of attendee" field. If you have any questions, the HP Provider Assistance Center is always available to help. They can be contacted at 1-800-842-8440 or locally in Farmington at (860) 269-2028.

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HUSKY Primary Care: Information and Expansion to Putnam and Torrington Areas

HUSKY Primary Care, Connecticut's Primary Care Case Management (PCCM) Pilot Program, is an enrollment option for HUSKY A (Medicaid for children and families) clients in which members enroll directly with participating Primary Care Providers (PCPs) in lieu of enrolling in a managed care organization (MCO). Members' health care is coordinated by the client's PCP or a care coordinator in the PCP's practice.

The program is currently an enrollment option for HUSKY A members in the greater Hartford, New Haven, Waterbury, and Windham/Willimantic areas. It will also be expanding to the Putnam and Torrington areas shortly. The Department is seeking additional Primary Care Providers in all six of these areas. The program pays participating PCPs \$7.50 per member per month (in addition to fees paid for direct services) to coordinate the care of patients who enroll directly with the PCP.

All Medicaid providers should note that medical services, providers, and facilities in the HUSKY Primary Care program are the same as in Medicaid/Title 19. Members use the gray CONNECT card for all services. Additionally, the same billing rules and rates as in Medicaid/Title 19 apply to covered goods and services provided to HUSKY Primary Care members, with the exception of behavioral health services. Behavioral health services follow Connecticut Behavioral Health Partnership (CT BHP) billing rules and rates, the same as for all other HUSKY members.

For more information, please see www.huskyhealth.com/PrimaryCare

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The Ins and Outs of Verifying Client Eligibility

Do you find verifying eligibility to be a daunting task? Do you cringe when the client has coverage in a program with which you are not familiar? Are you sure that the service you need to provide is a covered service under the client's benefit plan? If these are questions you have, don't fret. There is a great resource available to assist you with these questions. Best of all, this resource can be accessed directly from [the www.ctdssmap.com](http://www.ctdssmap.com) Web site. From the Home page, go to Information -> Publications -> and scroll down to the Claims Processing Information Panel and click on the link for Eligibility Response Quick Reference Guide.

This Guide walks you through every benefit plan and identifies:

- What Client population is covered by the Benefit Program;

- To whom claims should be submitted;
- To whom Prior Authorization (PA) requests should be submitted;
- And most importantly, What Services are covered by the benefit

Please remember: a client may have coverage with one or multiple benefit plans for the same date of service and that the coverage of one plan, for instance ConnPACE which is a drug only coverage, will not negate the coverage of another benefit plan such as QMB which covers the coinsurance and/or deductible due on a paid Medicare professional crossover claim.

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e-Prescribing – Have You Tried it?

Physicians, pharmacists, and other medical providers know that any error in a patient's prescription can have deadly consequences. Yet you know that oftentimes the traditional manual processes used to order and fill prescriptions leads to errors and delays.

You can reduce errors, improve client safety, and lower your overhead and administrative costs via an e-prescribing solution. These electronic prescription solutions, which are consistent with the Medicare Modernization Act of 2003, are focused on:

- **Improving client safety** — Eliminate medical errors and adverse drug events that result from misread or misunderstood handwritten prescriptions
- **Boost efficiency** — Automate renewals and reduce the number of workflows and telephone calls required to complete a prescription transaction
- **Increased accuracy** — Check medical, pharmacy, and medication histories; benefit coverage; and clinical appropriateness in one transaction
- **Enhanced patient satisfaction** — Transmit prescription information electronically to the client's pharmacy of choice
- **Compliance regulations** — Adhere to benefit guidelines and reduce exceptions for prior authorizations via access to preferred drug lists

Surescripts operates the country's largest electronic prescribing network. Connecticut Department of Social Services has been a certified payer in the Surescripts network since October 2009 and Connecticut

was ranked 8th in the country for 2008 for Surescripts' Annual SafeRx Awards, highlighting the top 10 states that send prescriptions electronically. The Connecticut Medical Assistance Program went live with e-Prescribing on October 14, 2009.

All Medicaid providers with Surescripts certified e-prescribing software have access to Medicaid, Medicaid LIA (Formerly SAGA), ConnPACE, CADAP, HUSKY, and Charter Oak enrolled clients for the following transactions:

- Eligibility
- Formulary
- Medication History



In order to access information for the Connecticut Medi-

cal Assistance Program population please contact your e-prescribing software vendor to download Connecticut formulary files. If you have any technical questions, please contact Surescripts Support at 1-866-765-1684 or email support-mn@surescripts.com. To learn more about the SafeRx awards and to view the complete state-wide report, visit www.surescripts.com/safe-rx-awards.html. This site has some great resources, such as access guides for physicians, buyer's guide worksheets, initiatives and incentives, and a wealth of other data to assist with e-prescribing adoption.

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Physician Providers

Vaccines for Children Program Update

Effective April 1st, 2010, vaccine procedure code 90670 (Pneumococcal Conjugate Vaccine, 13 Valent, For Intramuscular Use) has been added to the list of vaccines under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services Program. This vaccine has replaced procedure code 90669 (Pneumococcal Conjugate Vaccine, 7 Valent, For Intramuscular Use) on the EPSDT list. Under this program, providers receive vaccines free of charge from the Department of Public Health to administer to children enrolled in the Connecticut Medical Assistance Program. The



Department of Social Services reimburses providers for administering these vaccines to eligible clients under the age of 19. Providers do not receive any reimbursement for the vaccines, but the vaccine procedure code(s) needs to be billed along with the vaccine administration code(s) in order to receive reimbursement for the administration. The vaccines eligible for the EPSDT Services along with the vaccine administration codes is available in Chapter 5 of the Provider Manual. From the Web site www.ctdssmap.com, click on Information -> Publications -> Provider Manual -> Chapter 5 and find the information in the EPSDT section 5.11.

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Medicare Crossover Claim Denials for J-Codes

You know you included an NDC with the J-code claim you submitted to Medicare, so why have your crossover claims denied? This is an excellent question! The first question that comes to mind...did your claim include the NDC quantity and the NDC Unit of Measure (UOM)? If not, your claim most likely denied with Explanation of Benefits (EOB) code 841 'Units of measure required for NDC' and/or 842 'NDC units missing or invalid'. To alleviate these denials in the future, be sure to include both the NDC quantity and the NDC UOM on all J-code details submitted to Medicare and Medicaid.

Okay, so now you are probably thinking . . . what's the quickest and easiest way to correct your denied claims? Well, that's simple - through the Connecticut Medical Assistance Program Web site www.ctdssmap.com. Once you log on to your secure provider account, from your account Home page, go to Claim Inquiry. Either click on the Quick link or choose Claim Inquiry from the drop-down menu under Claims. Enter the Internal Control Number (ICN) for your denied claim or paid claim with a denied detail in the ICN

field and click search. The page will refresh and your claim will populate the screen. Scroll down to the Detail Panel and click on the segment that includes your J-code. The panel will populate with the information you submitted on your claim. Look at the last three fields in the left hand column:

National Drug Code	<input type="text"/>
NDC Quantity	<input type="text" value="0"/>
NDC Unit of Measurement	<input type="text"/>

All three fields **must** be populated for the detail to process. Enter the missing information, scroll down to the bottom of the claim and click the Resubmit button. That's it, you are done! The page will refresh and in a matter of seconds, you will know the status of your claim.

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Pharmacy Providers

Change to HUSKY B Pharmacy Tiered Co-Pay Schedule

Individuals enrolled in HUSKY B are subject to a pharmacy co-pay requirement. The co-pay amount assigned to the claim is based on the classification of NDCs submitted on the claim. Currently, the tiered co-pay schedule is:

\$3.00 co-pay for generic;
\$6.00 co-pay for brand; and
\$5.00 co-pay for family planning medication

Effective July 1, 2010, the co-pay structure will transi-

tion to a two tiered co-pay. The chart below identifies the new co-pay amounts:

Drug Classification	Co-pay Amount
Generic	\$5.00
Brand	\$10.00
Family Planning	Claim will assign either the Brand or Generic co-pay amount based on the NDC classification

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New Over-the-Counter (OTC) Restrictions

Beginning June 4, 2010 the Department of Social Services (DSS) implemented new restrictions to its coverage of over the counter medications in the Medicaid (Title XIX or fee-for-service Medicaid), HUSKY, and Charter Oak Programs. Specifically, coverage of OTCs would be limited to individuals under the age of 21. Exceptions to this are:

- Insulin and insulin syringes which will continue to be covered for all clients.
- Blood glucose test strips and lancets will continue to be covered for clients over the age of 21 under the Durable Medical Equipment (DME) benefit (pharmacies are urged to contact their software vendor to inquire on how to bill DME claims).
- Nutritional supplements for clients over the age of 21 who require tube feedings or those who cannot safely ingest nutrition in any other form.

The Department's policy has always required a prescription for coverage of OTC medications. This remains unchanged. Please note however, that any prescription or pharmacy claim for a nutritional supplement for a client over the age of 21 must now also include a valid diagnosis code to be covered. The prescribing practitioner must write the appropriate diagnosis code on the prescription or indicate the diagnosis code via electronic format. If the physician fails to provide a diagnosis code, the pharmacy must follow up with the prescriber prior to submitting the claim.

Many of the OTCs that have been eliminated from coverage with this new policy have both brand and generic federal legend alternatives which remain covered. In particular, these include prenatal vitamins and oral contraceptives. We urge all patients to discuss all options available with their physicians in hopes that providers will choose the best possible alternatives to ensure continued quality care.

The Department has fielded many calls from both clients and providers expressing their concerns over the new policy and understands the change can be alarming upon initial review. We want to take this opportunity to clarify and address some of the concerns to ensure the medical community that there are options available.

access2wellness® at:
<http://www.access2wellness.com/a2w/patient-welcome.html>

Needy Meds at:
<http://www.needymeds.org/>

Partnership for Prescription Assistance at:
<http://www.pparx.org/>

Patient Assistance at:
<http://www.patientassistance.com/>

RXAssist Patient Assistance Program Center at:
<http://www.rxassist.org/patients/default.cfm>

Together Rx Access® at:
<http://www.togetherrxaccess.com/Tx/jsp/home.jsp>

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Pharmacy Providers

Clarification on Prior Authorizations Required for Non-Preferred Medications

When a preferred drug included on the Preferred Drug List (PDL) is not the prescriber's 'preferred' agent, they are not restricted to the PDL and may write prescription for an alternate medication; however, prior authorization must be obtained in order for the prescription claim to process:

- If a prescription for a generic medication included within a therapeutic class on the PDL is written, the prescriber will be required to submit a prior authorization request for a non-preferred medication and include why the alternate therapy is required.
- If a prescription for a brand multi-source medication (a medication that is available as both the brand name and the generic) included within a therapeutic class on the PDL is written, the prescriber will be required to submit a prior authorization request for a non-preferred medication **and** a Brand Medically Necessary (BMN) and include why the alternate therapy is medically necessary. The pharmacy **must** have a prescription with the words 'Brand Medically Necessary' writ-

ten in the prescriber's handwriting on file; failure to provide written documentation in the event of an audit will result in the recoupment of the claim. A verbal or electronic prescription would need to be followed up by a hard copy prescription sent to the pharmacy with the appropriate documentation.

Additionally, if the brand name medication for a multi-source product identified as the preferred drug on the PDL is prescribed, prior authorization is not required, and the claim does **not** need to be submitted with a Dispense As Written (DAW) code of '1' for the pharmacy to receive brand reimbursement. If the prescriber has not indicated the brand product is medically necessary, the pharmacy may submit the claim with a DAW code of '5' to signify that the pharmacy dispensed the brand as the generic and will receive brand reimbursement as long as the brand name product remains preferred on the PDL.

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Dental Providers

New Husky B Client Cost-share for Dental Services

Effective July 1, 2010 all HUSKY B clients are required to pay for a portion of care provided for all endodontic, orthodontic, oral surgical, prosthodontic, restorative and adjunctive dental procedures. Providers may not charge HUSKY B clients more than the client's cost share indicated on the revised dental fee schedule.

The revised dental fee schedule has been posted to the Connecticut Medical Assistance Program Web site in the PDF and CSV

(Comma Separated Values) format and is accessible to providers by first going to the CT Medical Assistance Program Web site at www.ctdssmap.com:

1. Select **Provider**;
2. Scroll down and click **Provider Fee Schedule Download**;
3. Scroll down and click **Dental**

The fee schedule lists the Connecticut Dental Health Partnership (CTDHP) fee and the client's cost

share percentage. Please note, all other applicable CTDHP policies, regulations, prior authorization requirements and contact information remain unchanged.

Dental providers who have questions about the cost share requirements should contact BeneCare's Provider Services Staff at 1-888-445-6665.

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Behavioral Health Providers

New HUSKY B Client Cost-share for Behavioral Health Services

Effective July 1, 2010, all HUSKY B clients will be required to pay for a portion of care provided for all office-based outpatient behavioral health services. Providers may not charge HUSKY B clients more than the clients' cost-share for the same procedure. FQHC services are subject to these same cost-share requirements when T1015 is billed with a procedure code that is subject to cost-share.

Cost-share requirements are posted to the CT Behavioral Health Partnership (CT BHP) Web site at: www.ctbhp.com select **For Providers**, then **Covered Services/Fees** on the left hand navigational menu, then click on the **HUSKY B Client Cost-Share** hyperlink.

Cost-share requirements are also posted to the Connecticut Medical Assistance Program Web site in the PDF format and will be accessible to providers by going to the CT Medical Assistance Program Web site:

- www.ctdsmap.com, select **Provider**,

- scroll down and click **Provider Fee Schedule Download**,
- scroll down and click **Behavioral Health Partnership** PDF format,
- Following page 16 of the fee schedule; Exhibit D - Covered Services Table lists the codes that will have the cost-share applied and the amount of the cost-share.

Please note, all other applicable CT BHP policies, regulations, prior authorization requirements and contact information remain unchanged.

CT BHP providers who require assistance with the HUSKY B cost-sharing requirements should contact the CT BHP at 1-877-552-8247.

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DME Providers

New Enrollment/Re-enrollment Criteria for DME Providers

As a result of CMS' DME Accreditation Requirement, DME providers wishing to enroll, or those enrolled providers due to re-enroll in the Connecticut Medical Assistance Program must now provide a copy of their Medicare certification along with all other required evidentiary documentation. **Your application cannot be completed without this certificate.** To identify what evidentiary documentation is required to be provided by DME providers, please refer to the Provider Matrix. From the Web site Home page, go to Provider -> Provider Matrix, then scroll down to **Additional Evidentiary Documentation to be Sent to HP** and click on the link for [Enrollment Requirements for MEDS Providers](#).

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DME Providers

Don't Underestimate The Power of DME Modifiers – They Matter and Can Impact the Status of Your Claim

Knowing which modifiers are required and when can greatly reduce the number of claim denials you receive. For example: submitting a claim for the repair of equipment with modifier RB (Replacement of a part of a DME repair) alone, or a rental claim with only the RR (Rental) modifier will undoubtedly result in a claim denial with Explanation of Benefits (EOB) code 4272 'Procedure code and modifier combination is not valid for billing provider'.

Claims submitted in this manner will deny because these modifiers must be billed in conjunction with another modifier. Referencing the following chart may save you from submitting your claims incorrectly:

First Modifier	Description	Second Modifier	Description
RB	Replacement of a part of a DME repair	NU	New
RR	Rental	NU UE	New Used

Wondering where to find more information on modifier requirements?

- **Chapter 8.3 of the MEDs Provider Manual** identifies unique claim submission requirements that apply for specific modifiers.
- The **Fee schedule** identifies if a procedure may be rented, repaired, or purchased and whether Prior Authorization (PA) is required for all or specific modifiers.
- **Provider Bulletin:**
 - PB09-19 'Clarification of MEDS Fee Schedule and Policy'** introduces the modifier KA 'Wheelchair add on option/accessory'.
 - PB09-08 'Updated MEDS Fee Schedule and Replacement of RP Modifier'** introduced modifier RB (Replacement of a part of a DME repair).
 - PB04-17 'Changes to Medical Equipment, Devices and Supplies (MEDS) Services Fee Schedule'** introduced new modifier requirements for rentals.

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Vision Providers

Change to Coverage of Eyeglasses

Effective June 1, 2010, the Department of Social Services will cover only one pair of eyeglasses per year for Connecticut Medicaid fee-for-service clients who are 21 years old or older. Clients under 21 years old will be allowed replacement eyeglasses under Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services. Prior authorization will not be needed to replace a pair of glasses to clients under 21 years of age. Providers can verify whether a client has received eyeglasses within the previous 365 days by calling HP's Provider Assistance Center toll free at 1-800-842-8440 or locally at (860) 269-2028.

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Transportation Providers

Reminder of the Update to the Transportation Prior Authorization Process

Effective November 9, 2009, an update was made to the transportation Prior Authorization (PA) process. PAs submitted by First Transit and LogistiCare identified by the system to have overlapping dates of service for the same provider, same client and same procedure codes as an existing PA are voided. The existing PA is modified to include all dates of service. Authorized units, used units and available units are modified to include totals from all PAs. A PA may have one line item voided and one line item altered. When performing a PA search on the Web site, providers should look at the detailed information under the "Search Results" and "External Text" panels to obtain information about PAs that have been modified or voided.

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Appendix

Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
09/06/2010	Labor Day	Closed	Closed
10/11/2010	Columbus Day	Open	Closed

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Provider Bulletins

Below is a listing of all Provider Bulletins that have been posted to www.ctdssmap.com since the last Newsletter was published. To see the complete messages, please visit the Web site. All Provider Bulletins can be found by going to the Information -> [Publications](#) tab.

- [PB10-41](#) Prior Authorization and Claims Processing Changes
- [PB10-40](#) National Drug Codes (NDC) Required for Outpatient Hospitals Claims for Medicaid Low Income Adult
- [PB10-39](#) July 1, 2010 Elimination of the ConnPACE and SAGA Preferred Drug List (PDL)
- [PB10-39](#) July 1, 2010 Changes to the Connecticut Medicaid Preferred Drug List (PDL)
- [PB10-39](#) Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)
- [PB10-38](#) National Health Reform - State Administered General Assistance Program Becomes Medicaid for Low Income Adults
- [PB10-37](#) National Health Reform - State Administered General Assistance Program Becomes Medicaid for Low Income Adults
- [PB10-36](#) Changes to Connecticut Home Care Cost Sharing
- [PB10-35](#) New HUSKY B Client Cost-share for Behavioral Health Services
- [PB10-34](#) Change to Existing HUSKY B Pharmacy Tiered Co-Pay Schedule Effective July 1, 2010
- [PB10-33](#) CADAP Formulary Update - Effective July 1, 2010

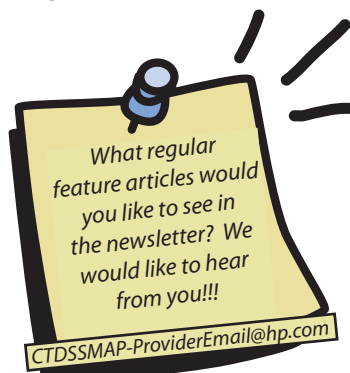
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Appendix

Provider Bulletins

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

- PB10-32 Notice of Changes to the Dental Fee Schedule concerning Client Cost Shares for HUSKY B
- PB10-31 Billing Clarification for Diabetic Supplies
- PB10-31 Requirements for Coverage of Over-the-Counter Nutritional Supplements
- PB10-30 Charter Oak Health Plan Reporting Updates
- PB10-29 Charter Oak Health Plan Co-Insurance/Deductible Updates
- PB10-28 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (Medicaid, ConnPACE, CADAP, HUSKY and Charter Oak Programs)
- PB10-27 CADAP Formulary Update - Effective June 14, 2010
- PB10-26 Change in Professional Fee (Dispensing Fee) and Additional Information on the Elimination of Over-The-Counter (OTC) Coverage
- PB10-25 Important Change to the Coverage Policy of Eyeglasses
- PB10-24 Discontinuation of Coverage For Over The Counter (OTC) Products
- PB10-23 Exclusion of Individuals and Entities from Participation in Connecticut Medical Assistance Programs
- PB10-22 Emergency Mobile Psychiatric Services Rate Increase and Required Use of Modifier
- PB10-21 New Maximum Allowable Cost (MAC) Pricing for Pharmacy
- PB10-20 Change to Pharmacy Claims Processing For Clients Under 21 With Third Party Liability (TPL) Coverage
- PB10-19 Integrated Care Requirements for Children/Adolescents with Co-Occurring Mental Health and Substance Use Disorders in the Enhanced Care Clinics under the Connecticut Behavioral Health Partnership, Medicaid Fee- For-Service and Charter Oak Health Plans
- PB10-18 Integrated Care Requirements for Children/Adolescents with Co-Occurring Mental Health and Substance Use Disorders in the Enhanced Care Clinics under the Connecticut Behavioral Health Partnership and Charter Oak Health Plans
- PB10-17 Reporting Requirements Related to Payment Adjustments for Hospital Acquired Conditions
- PB10-16 Physician Fee Schedule: Addition of HCPCS A4264
- PB10-15 Integrated Care Requirements for Adults with Co-Occurring Mental Health and Substance Use Disorders in the Enhanced Care Clinics under the Connecticut Behavioral Health Partnership, Medicaid Fee-For-Service and Charter Oak Health Plans
- PB10-14 Integrated Care Requirements for Adults with Co-Occurring Mental Health and Substance Use Disorders in the Enhanced Care Clinics under the Connecticut Behavioral Health Partnership and Charter Oak Health Plans



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HP Enterprise Services
Box 2991
Hartford CT, 06104

www.ctdssmap.com