June 2015
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- Update of Contact Information
- Subscribe Today to Receive CMAP E-mails!!!
- Reminder: Access to Remittance Advices and Electronic Funds
- Need to Return a Claim Payment?

Table of Contents

Trading Partners

Update of Contact Information

The EDI Support Department requests that all CMAP Trading Partners review and update their contact names, telephone numbers, and e-mail addresses using the CMAP Secure Web Portal www.ctdssmap.com – Secure Site log in link.

Keeping your contact information up to date allows the EDI Support Department to contact you in a timely manner when EDI submission errors are detected, and to provide you with information which will assist in resolving errors. Whenever possible, provide direct telephone numbers and/or correct telephone extensions to facilitate effective outreach efforts.

To update your contact information, log in to the Secure Web Portal with your Trading Partner Web User ID and password and select the Trading Partner Profile/Update Wizard to update the Trading Partner Name, Address and Contact information to be used by the EDI Support Department and the CT Department of Social Services Medical Assistance Program. It is necessary to proceed through all of the Wizard panels, providing an Authorized Signature and clicking on the Submit button to save these changes to your profile. In addition, you should update Account Maintenance, where the Contact Name, Telephone Number and E-Mail may be updated for your Secure Web Account management. Please refer to the CMAP Provider Manual, Chapter 10, for detailed instructions on updating Secure Trading Partner Web accounts.

The contact information contained within your EDI X12N 837 claim transactions should also be reviewed and updated. This information is contained within the Loop 1000A Submitter PER segment, and may include telephone numbers and e-mail address. Please refer to the relevant Implementation Guide for your claim type, available through the Washington Publishing Company.

Resources:
EDI Help Desk: 1-800-688-0503
EDI Support E-Mail: CTEDISupport@hp.com
CT interChange Provider Manual – Chapter 10 Web Portal and AVRS
Washington Publishing Company: http://www.wpc-edi.com/.

Back to Table of Contents

All Providers

Subscribe Today to Receive CMAP E-mails!!!

The Department of Social Services (DSS) and HP are pleased to announce that, providers and their office staff are now able to subscribe to receive pertinent CMAP program information via e-mail messages. If you have subscribed, you should now be receiving e-mail messages from CMAP.

There are many benefits to the electronic delivery of communication, including:

- Faster distribution of information to the provider community
- Any office personnel can subscribe to receive program information via e-mail
- Provides a simplified subscription process that can be completed very quickly allowing information to get into the right hands

IMPORTANT! As of June 30, 2015, DSS will no longer distribute any paper communications to providers. If you have not already done so, please subscribe immediately to receive CMAP information electronically. If you choose not to subscribe, all information, such as provider bulletins and workshop invitations, will continue to be available on the www.ctdssmap.com Web site for you to access and review. However, subscribing to receive e-mail notices will alert you to policy and program changes as they occur. DSS and HP use electronic messaging to distribute documents such as provider bulletins, policy transmittals, workshop invitations, and program updates and reminders. All enrollment and re-enrollment letters will continue to be mailed to the provider community.

Please refer to Provider Bulletin 2015-23 for detailed information on how to subscribe.

Please note: Some providers are reporting that the electronic messaging emails are being sent to a recipient's "Spam" or "Junk" email folders. If a provider finds that this is happening, please open the Junk Mail folder and right click on the email from CTDSSMAP@hp.com, next click on "Not Junk" or "Never Block Sender".

Please refer to Provider Bulletin 2015-23 for detailed information on how to subscribe.

Back to Table of Contents

Reminder: Access to Remittance Advices and Electronic Funds

As an important reminder, the Department of Social Services (DSS) no longer prints and distributes Remittance Advices (RAs) to providers. Rather, a provider may log into their secure Web portal account at www.ctdssmap.com and download their RA. Provider RAs are in a Portable Document Format (PDF) and are typically available for providers to download the Tuesday following a claim cycle. Once on the account home page, click on "Download Remittance Advices" from the Quick Link box located in the upper right hand corner or click on Trade Files and then Download. Select "Remit. Advice (RA) – PDF" from the Transaction Type menu and then click on search. DSS recommends that providers save a copy of their RA to their local computer system for future reference as only the last 10 RAs are stored on the www.ctdssmap.com Web site.

Additionally, payments to enrolled CMAP providers are issued via electronic funds transfer (EFT) to the provider's financial banking institution. There are no longer any exceptions under which providers may receive a paper check. Once enrolled in EFT, providers may change their EFT data at any time via their secure Web portal account by clicking on the Demographic Maintenance tab. Only the main account holder is permitted to make EFT changes.

Back to Table of Contents

All Providers

Provider Training is Available

Are you or your office staff in need of a refresher on current claim submission guidelines? If you've answered yes to either question, please visit the CMAP Web site www.ctdssmap.com to learn more about available training opportunities and/or accessing copies of presentations from past training sessions. The new provider workshop, which is offered quarterly, is designed to provide a basic understanding of the Connecticut Medical Assistance Program and a Web portal overview of the CMAP Web site. Our annual refresher workshops are designed to give already enrolled providers a refresher on current CMAP policy and claim submission guidelines, as well as announce any upcoming changes that are new to CMAP and how they will impact providers. To inquire on workshop opportunities and/or workshop materials, visit the CMAP Web site. Once on the Home page, select "Provider" then click on "Provider Services". Scroll down to "Provider Training" and click "here". Here you will find current and past training sessions under "Workshops" and/or "Materials".

To register for an upcoming training session, click on the topic of your choice under "**Workshops**", click on "Registration Form/Directions", then click on the training session of your choice and register or follow the steps provided under "How To Register For A Workshop" if you require further assistance with the registration process.

To access materials from a past training session, click on the topic of your choice under "**Materials**", then click on presentation under "Training Materials". You can save a copy of the presentation to your computer and/or print the presentation for later reference. Additional questions regarding training may be directed to the HP Provider Assistance Center Monday through Friday 8:00 a.m. – 5:00 p.m. at 1-800-842-8440.

Back to Table of Contents

Need to Return a Claim Payment?

There is no need to ever submit a paper Paid Claim Adjustment Request (PCAR) form or submit a refund check in order to return payment received on a previously paid claim. This includes claims that may exceed the timely filing limit. The Web Claim Submission tool on the secure Web portal allows providers to easily void claims. Access this tool via the www.ctdssmap.com Web site by logging into the Secure Web portal and selecting "Claim Inquiry". Enter the appropriate search information to identify the claim. Once the claim is returned from the claim inquiry, scroll down to the bottom of the claim and click on the Void button. It is that simple! A claim void may also be submitted via an electronic 837 ASC X12 file. The frequency code of "8" is submitted to recoup a previously paid professional or dental claim. An "8" in the third digit of the Type of Bill is submitted to recoup a previously paid institutional claim.

Back to Table of Contents

ICD-10 Implementation is Coming Up!

The ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets on October 1, 2015. The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs.

Are you feeling overwhelmed with the thought of transitioning to ICD-10? After all, the number of diagnosis codes will increase from 14,000 under ICD-9 to 69,000 under ICD-10 CM (Clinical Modification). Consider the following to ease your mind a bit and plan for the transition with a composed attitude:

- You don't have to use 69,000 codes. The majority of providers do not use all 14,000 diagnosis codes available in ICD-9 now, nor will it be required to use the 69,000 codes that ICD-10 offers. As you do now, your practice will use a very small subset of the codes.

  You can start now by comparing ICD-9 codes commonly used in your office to the corresponding ICD-10 codes. If necessary, improve clinical documentation to capture all the information needed to identify ICD-10 codes and acquire ICD-10 code training.

- You will use a similar process to look up ICD-10 codes that you use with ICD-9. Increasing the number of diagnosis codes does not necessarily make ICD-10 harder to use. As with ICD-9, an alphabetic index and electronic tools are available to help you with code selection.

  Check your software for an ICD-10 look up function. Contact your vendors to confirm they are ICD-10 ready and how they will help you get ready.

- Outpatient and office procedure codes aren't changing. The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of Current Procedural Terminology (CPT) for outpatient and office coding. Your practice will continue to use CPT codes.

  Please note: ICD-10-PCS (Procedure Coding System) inpatient procedure coding, for use in U.S. hospital settings, will also be implemented on October 1, 2015. This will be used by hospitals only for their inpatient procedures.

- Connecticut Medical Assistance Providers who submit their claims in an ASC X12 format, have the opportunity to conduct testing with HP before the ICD-10 transition. Testing will ensure that you can submit claims with ICD-10 codes. Test how well your systems work together to send and receive codes – focus on transactions that affect your practice the most.

  Please contact HP at CTICD10testing@hp.com if interested in testing for ICD-10 compliance on your ASC X12 files. Testing is not offered for Web claims or paper claims submission.

Stay Informed: DSS and HP are maintaining an ICD-10 Important Message on the Home page of our Web site at www.ctdssmap.com. The ICD-10 Important Message contains links to key CMS-support materials, external provider resources, and training documentation to aid in the successful implementation of ICD-10. We urge our providers to check this Important Message frequently to stay informed for a successful implementation of ICD-10. Get ready now for ICD-10!

Back to Table of Contents

Ordering, Prescribing, Referring (OPR) Providers Re-enrollment Reminder

State of Connecticut Regulations for the Department of Social Services (DSS), section 17b-262-524 Provider Participation Policy, requires the periodic re-enrollment of all providers. This also includes those providers enrolled as an ordering, prescribing, referring (OPR) provider. Please note that re-enrollment timeframes vary based on provider type. As a result, some OPR providers have now reached the timeframe in which they are due to re-enroll. A notice to re-enroll is mailed to providers six (6) months in advance of a provider's re-enrollment due date. That re-enrollment due notice contains the Application Tracking Number (ATN) and the AVRS ID required to access the re-enrollment application via the online re-enrollment Wizard. Once on the Wizard, existing data is pre-populated for providers to confirm or update.

Important! It is imperative that providers successfully complete the re-enrollment application as quickly as possible upon receipt of their notice. Please note that each application, once submitted by the provider, must then be processed by HP and the Department of Social Services' (DSS) Quality Assurance Unit. The application must be submitted to allow adequate time for these processes, which typically takes several weeks to complete. Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from the Connecticut Medical Assistance Program (CMAP). Claims submitted by the billing provider for reimbursement with the deactivated provider as the ordering, prescribing or referring provider claim will be denied for failing an OPR edit.

Back to Table of Contents

Autism Spectrum Disorder (ASD) Evaluation and Treatment Services

Effective January 1, 2015, the Department expanded its coverage of Autism Spectrum Disorder (ASD) services for Medicaid enrolled clients (HUSKY A, C, or D) under the age of 21 for whom ASD services are medically necessary.

In order for an individual to receive treatment services, he or she must have a comprehensive diagnostic evaluation that recommends ASD services based on an ASD diagnosis consistent with the Diagnostic and Statistical Manual for Mental Disorder (DSM 5) definition of Autism Spectrum Disorder.

The following procedure codes are covered for ASD: 0359T "Comprehensive Diagnostic Evaluation (CDE) ", H0031 "Behavioral Assessment", H0032 "Treatment Plan Development" and H2014 "Treatment Intervention Services." These services require prior authorization (PA) from the Medicaid Behavioral Health Administrative Services Organization (ASO), Value Options.

For questions about ASD, providers can refer to Provider Bulletin PB 2014-99 "Autism Spectrum Disorder (ASD) Evaluation and Treatment Services".

Back to Table of Contents

Hospitals

340B Hospital Billing Changes

Effective for dates of service June 1, 2015 and forward, 340B entities are required to bill a valid HCPCS procedure code when billing specific pharmacy Revenue Center Codes (RCCs) on an outpatient claim. Outpatient 340B Pharmacies will be required to bill a valid HCPCS code with the following RCCs: 250 – 253, 258-259, and 634-637.

340B entities will remain exempt from the Deficit Reduction Act (DRA) requirements to include the National Drug Code (NDC) on the UB-04 and CMS-1500. When billing for HCPCS on outpatient claims, please refer to the provider drug search on the Web to determine the HCPCS code. A drug search can be performed at the Web site www.ctdssmap.com, by selecting "Provider" then "Drug Search" and entering the NDC.

For those drug products that do not have an associated HCPCS code, one of the following HCPC codes should be used: J3490 Unclassified Drugs, J3590 Unclassified Biologics, J8999 Prescription Drug, Oral, Chemotherapeutic, NOS or J9999 Not Otherwise Classified, Antineoplastic Drugs.

All claim details with these RCCs that are not billed with a valid HCPCS code will deny for Explanation of Benefits (EOB) code 840 – "HCPC Required when Drug Revenue Code is Billed".

Back to Table of Contents

Ambulatory Payment Classification (APC)

DSS will move from the current system of hospital outpatient payment methodology based on Revenue Center Codes (some paid based on fixed fees, some based on a ratio of costs to charges) to a prospective payment system based on the complexity of services performed. This change is scheduled for January 1, 2016.

The reasons for the move to APCs is to streamline policy to be consistent with industry standard payment practices (specifically, Medicare payment policy) and maintain a long-term commitment to goals of improved accuracy, predictability, equity, timeliness, and transparency of hospital payments for all Medicaid beneficiaries.

Hospitals should refer to the Hospital Modernization Web page on the www.ctdssmap.com Web site often, as this will be continuously updated throughout the year with information pertaining to the APC implementation.

Back to Table of Contents

Claim Submission/Resolution Reminders

Client Eligibility - Providers are reminded to check client eligibility when first receiving service orders on a new client. Non-Medical claims submitted for clients without a CHC benefit plan on their eligibility file will deny. Clients who do not have a CHC benefit plan should be referred to the Department of Social Services (DSS) Home and Community Based Services Unit, formerly the Alternate Care Unit (ACU), via e-mail. A list of CHC benefit plans, the e-mail address for submitting eligibility issues and information required to process your inquiry can be found in the Connecticut Home Care section of Chapter 8 "Claim Submission Instructions" of the provider manual located on the on the www.ctdssmap.com Web site. From the Home page, click on Publications, scroll down to provider manuals chapter 8, select Connecticut Home Care from the drop down menu, and click "View Chapter 8."

Prior Authorization – All Services (non-medical and medical) must be on the care plan of a client with a CHC benefit plan with or without a HUSKY benefit plan on their eligibility file, in order for the provider to receive payment. Authorized services can be found under Prior Authorization Inquiry under the Provider's secure Web account. Providers should carefully review services ensuring the appropriate procedure code or code list has been authorized, including the number of units and frequency of service (weekly, monthly, span dates of service) within the time frame of service to be provided (authorized effective and end date) to cover the services to be billed. To determine which codes or codes with modifiers are covered based on the code list authorized, providers should refer to the Procedure Code/Frequency Crosswalk.

Discrepancies in the services authorized, including missing services, should be reported immediately to DSS (for self-directed clients) or the Access Agency managing the client. Contact information to expedite the processing of service authorizations can be found in the "Welcome to the CT Home Care Program Implementation" Important Message located on the www.ctdssmap.com Web site Home page.

Care Plan changes, such as those due to a hospitalization or change in service, may impact claims already paid against an existing Prior Authorization. As a result, HP performs monthly claims reprocessing to recoup and reprocess claims that would now process the same against a different PA or pay more or less than previously paid. Providers are reminded region 52 claims that are recouped with an EOB code 8236 "Claim was recouped due to a PA change" will not appear on the provider's RA, if the reprocessed region 24 claims have no financial impact to the provider. Both the recouped and reprocessed claims, however, will be available on the provider's secure Web account. The region 24 claim will appear with an EOB code 8237 "Claim Systematically Reprocessed due to a PA Change-Information Only". Claims that recoup (region 52) and reprocess (region 24) with EOB 8238 "Claim Systematically Reprocessed Due to a PA/Service Order Change" may have a positive or negative impact to the provider. It is suggested that claims with a negative impact be reviewed to determine the need for further action.

Claims Resolution - Providers are reminded that Chapter 12 "Claim Resolution Guide" of the provider manual provides guidance in the resolution of common claims processing errors. Providers should first carefully review their denied claims for their own data entry errors. For example, claims or details on claims that deny with EOB 5151 "Units billed were cutback or denied as they exceed the frequency of service allowed on the care plan" may be the result of a provider billing error in transposing units on the claim detail rather than the Access Agency not authorizing a sufficient number of units. Providers should first review all claim details submitted within the frequency of the denial to determine if the denial is the result of a provider error.

Back to Table of Contents

Individuals with Intellectual Disabilities (ICF/IID) Enrollment/Re-enrollment on the Web

Currently, Nursing Home and ICF/IID providers are required to enroll/re-enroll using a paper application. Accompanying the paper application, providers are required to submit "Follow on Documents" to HP's Provider Enrollment Unit. The Department of Social Services (DSS) is implementing a number of enhancements to streamline the enrollment/re-enrollment application process which will require providers to enroll/re-enroll via the Connecticut Medical Assistance Program (CMAP) Web site at www.ctdssmap.com. Some highlights of these enhancements will include but are not limited to:

- Replacement of the current Nursing Facility paper application with a Web based application that incorporates the standard provider agreement and addendum for nursing homes or ICF/IID providers
- Extension of the re-enrollment for Nursing Facilities and ICF/IID providers to once every 5 years
- Providers will be notified 8 months in advance of their re-enrollment due date

The on-line Wizard will collect all data necessary from Nursing Home and ICF/IID providers to enroll/re-enroll. The provider agreement is included in the on-line application and is signed electronically. HP will coordinate monthly verifications with the Department of Public Health (DPH) between a provider's re-enrollment periods to ensure license compliance on an ongoing basis. DPH does not license ICF/IID facilities; these providers will need to submit a copy of their current license from the Department of Developmental Services (DDS) to HP's Provider Enrollment Unit to complete their enrollment/re-enrollment application. This is what is referred to as a "Follow On Document".

Important Points to Remember:

- Providers submitting an application for the first time must enroll using the HP Provider Enrollment Wizard located on the CMAP Web site starting July 1, 2015
- Providers with a re-enrollment due date **prior to July 1, 2015** should follow the instructions in their "notice to re-enroll" to successfully complete their re-enrollment application
- Providers with a re-enrollment due date **July 1, 2015 through July 31, 2015** have the option of following the instructions in their "notice to re-enroll" and submitting a paper application or re-enrolling on the www.ctdssmap.com Web site.
- Providers with a re-enrollment due date **August 1, 2015** and later must re-enroll using the HP Provider Enrollment Wizard.

In any case, providers will continue to receive a letter notifying them that it is time to re-enroll and the process to follow for that re-enrollment (paper versus Web).

Please refer to provider bulletin PB2015-42 for additional information regarding these changes.

Back to Table of Contents

All Providers

Why are My Claims Denying for Medically Unlikely Edits?

In November 2010, the Department of Social Services (DSS) adopted the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which included the Medically Unlikely Edit (MUE) to reduce the paid claims error rate. The MUE edit occurs when a provider bills more than the maximum edit units of service for a HCPCS/CPT code than would be reported under most circumstances for a single beneficiary on a single date of service.

MUEs were developed based on anatomic considerations, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment. Prior to implementation, all edits were reviewed by national healthcare organizations, and their alternative recommendations were taken into consideration. Subsequently, there have been quarterly updates increasing the number of edits.

According to the CMS definition, MUEs are auto-deny edits; however, during the NCCI implementation CMS had allowed DSS to cutback the reimbursed units of service billed in excess of the MUE criteria. Effective April 1, 2015, claims exceeding the medically unlikely units have started to auto-deny instead of cutting back to allowed units and post EOB 0770 "MUE UNITS EXCEEDED". Providers will need to resubmit the denied HCPCS/CPT codes with the correct units.

Quarterly MUE updates are published on the CMS Web Site and providers are asked to refer to the CMS MUE tables by clicking on the link below to obtain published quarterly additions, deletions, and revisions:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

It is important to note that not all providers are subject to MUEs. For example, transportation providers are excluded from MUE claim processing methodology.

Back to Table of Contents

Appendix

Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
7/3/2015	Independence Day Eve	Closed	Closed
9/7/2015	Labor Day	Closed	Closed
10/12/2015	Columbus Day	Open	Closed

Back to Table of Contents

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.

PB15-42 Nursing Home and ICF/IID Enrollment/Re-enrollment on the Web
PB15-41 New Hepatitis C Prior Authorization Criteria - Olysio, Harvoni, Sovaldi and Viekira Pak
PB15-41 Reminder About the 5 day Emergency Supply
PB15-41 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)
PB15-41 July 1, 2015 Changes to the Connecticut Medicaid Preferred Drug List (PDL)
PB15-39 Obstetrics Pay for Performance Program
PB15-38 Prior Authorization of Home Health Aide and Extended Nursing Services
PB15-37 Tobacco Cessation Group Counseling Services
PB15-36 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health and CADAP Programs)
PB15-35 Expedited Medicaid Eligibility Processing for Individuals with Medical Emergencies
PB15-34 Prior Authorization of Genetic Testing Services
PB15-33 Department of Transportation (DOT) Construction
PB15-32 Provider Audit Trainings
PB15-31 (REVISED) Prior Authorization for Medical Inpatient Hospital Stays
PB15-30 Private Non-Medical Institution (PNMI) Rates for Adult Mental Health Rehabilitation Services
PB15-28 Electronic Time Keeping for Home Health Agencies and other Home and Community Based Service Providers
PB15-27 Changes in Dental Coverage for Bitewings
PB15-26 Revised Billing Instructions for Outpatient Claims
PB15-25 Digital Breast Tomosynthesis
PB15-24 Temporary Delay for Pricing of Complex Rehabilitative Technology Equipment - MEDS

Back to Table of Contents

HP Enterprise Services
Box 2991
Hartford CT, 06104
www.ctdssmap.com