October 2014
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- Inpatient Hospital Payment Modernization/APR-DRG
- Hospital Based Practitioners – Inpatient Services
- Provider Re-enrollment Updates
- New DME Provider for Hospital-Grade Breast Pumps
- Patient Liability Updates

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General Acute Care Hospitals

Inpatient Hospital Payment Modernization/APR-DRG

As required by Section 17b-239 of the Connecticut General Statue, the Department of Social Services (DSS) is changing inpatient hospital reimbursement for general acute care hospitals and children's hospitals from the current model of interim per diem rates and case rate settlements to an APR-DRG system where hospital payments will be established prospectively. These changes do not apply to chronic disease hospitals, psychiatric hospitals, or free-standing birth centers. The goals of the conversion are:

1. Administrative simplification for hospital providers and the Department by following established Medicare reimbursement policies and procedures as closely as possible.
2. Greater accuracy in matching reimbursement amounts to relative cost and complexity.
3. Greater ability to partner with Medicare, commercial insurers and other payers in developing innovative payment strategies that reward improved quality as opposed to greater quantity of care.
4. Greater transparency in the payment methodology.

In preparation for changes in the reimbursement methodology for hospitals, the Department of Social Services (DSS) and HP created a new Web page link titled "Hospital Modernization". The Web page includes the following: Quick links, DRG Provider Publications, Hospital FAQs, Hospital Important Messages, DRG Calculator, Provider Manuals, and Contact Information. Please refer to it periodically for the most current information.

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Hospital Based Practitioners – Inpatient Services

Hospitals will need to create at least one physician group in order to bill for inpatient professional services for dates of service January 1, 2015 and forward. This change in policy is an integral component of the Department of Social Services' overall hospital modernization and healthcare payment reform initiative, mandated by Section 17b-239 of the Connecticut General Statutes, as amended in 2013. This will ensure that the hospitals will be reimbursed outside of the APR-DRG classification system for their inpatient professional fees for dates of service January 1, 2015 and forward. Hospitals will also need to ensure their hospital based practitioners (performing providers) are enrolled in the Connecticut Medical Assistance Program (CMAP) under a participation type of Employed/Contracted by an organization.

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Provider Re-enrollment Updates

The Department of Social Services (DSS) and HP recently announced an update to the Provider Re-enrollment Process. This update affects the re-enrollment due notification process and the ability for providers to view their re-enrollment due date on the Home page once logged in to their Secure Web portal.

As communicated in PB 2014-52, providers were informed that any re-enrollments with a due date beginning March 1, 2015 and forward will begin receiving their notice to re-enroll as early as September 1, 2014. Providers due for re-enrollment prior to March 1, 2015 will not be impacted by this change and should continue to follow the current re-enrollment procedures/timelines.

As a reminder, providers with a re-enrollment due date of March 1, 2015 and forward are strongly encouraged to complete the re-enrollment application upon receipt of their notice to re-enroll even though the letter indicates a six month re-enrollment period. The application must be submitted timely to allow adequate time for both HP and the DSS Quality Assurance Unit to review and process the application. Providers that have not successfully re-enrolled after three (3) months will receive a reminder letter reiterating the date in which the re-enrollment application must be completed; thereafter, applications still 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). Providers are encouraged to view their re-enrollment due date located on the Secure Web portal home page to avoid being dis-enrolled from the program. Organizations/Groups can view the re-enrollment due dates of their members by accessing the "Maintain Organization Members" panel. This enhancement allows providers to better track their re-enrollment due dates prior to receiving their notice to re-enroll. Please refer to PB 2014-52 for more information.

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Remittance Advice Availability After a Claim Cycle

Providers are reminded that the RA on the Web is available to providers by close of business on Tuesday and the ASC X12N 835 Health Care Claim Payment/Advice is available to providers by close of business on Wednesday after the claim cycle date, unless otherwise scheduled due to a holiday. Although often available earlier in the day, providers should not expect that the RA will always be available before close of business on the scheduled day. Should there be a delay where the RA will not be available as scheduled, a delay notification in the form of an Important Message will be posted to the www.ctdssmap.com Web site Home page, under Important Messages, informing providers of the delay and when the RA is expected to be available.

Providers should refer to the current cycle schedule on the www.ctdssmap.com Web site under Provider > Provider Services > Schedules > Cycle/Claim Submission Schedule for further information. Providers are further reminded that **only the last 10 RAs are available on the Web via their Provider Secure Web Account and only the last 10 835 electronic RAs are available on the Web via their Trading Partner Secure Web Account. Providers should down load their Web RA and 835 after each claim cycle for future reference.**

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Did You Know That There is a Newly Enrolled Medicaid Durable Medical Equipment (DME) Provider That Offers Rentals for Hospital Grade Breast Pumps?

The Department of Social Services (DSS) is pleased to announce that a newly enrolled DME provider is available to provide rentals of hospital grade breast pumps to Medicaid eligible mothers with hospitalized infants who meet the medical necessity guidelines. The provider is "Yummy Mummy", a company that is based out of New York. Prior authorization for a hospital grade breast pump is required and is only covered upon the mother's discharge from the hospital.

Please refer to the detailed guidelines found at www.huskyhealth.com. To request the rental of a hospital-grade pump, providers must call Yummy Mummy's insurance department at 1-855-87-YUMMY (855-879-8669).

For more information on the company, please log onto: www.yummymummystore.com.

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Chapter 12 Claims Resolution Guide

Are you aware that we have a Claims Resolution Guide to help resolve common claim denials?

Chapter 12 of the provider manual is a Claims Resolution Guide to assist providers with the most common explanation of benefit (EOB) codes that may be seen on a Remittance Advice (RA). This guide provides a brief explanation of the reason why claims were either suspended or denied. The guide also provides a detailed description of the cause of each EOB and more importantly, a tip and resolution for correction to the claim, in order to resolve the error condition. Keep in mind that new EOBs are continuously added to this chapter as new programs and policies are implemented.

Have a denial that is not in Chapter 12?

If you would like to submit an EOB denial that is not seen in Chapter 12, please send an email to CTDSSMAP-ProviderEmail@hp.com. Chapter 12 can be accessed by going to the Connecticut Medical Assistance Program Web site at www.ctdssmap.com. From the Home page, please click on Information, then Publications, followed by -Provider Manuals,- and scroll down to Chapter 12 "Claims Resolution Guide".

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In ICD-10 News: The Importance of Clinical Documentation

On July 31st, 2014, the U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015 as the new compliance date for health care providers, health plans and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. This deadline allows providers, insurance companies, and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on October 1, 2015.

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. ICD-10 consists of two parts:

- ICD-10-CM diagnosis coding which is for use in all U.S. health care settings. This will be used by all providers.
- ICD-10-PCS inpatient procedure coding which is for use in U.S. hospital settings. This will be used by hospitals only for their inpatient procedures.

The rest of this article deals with ICD-10-CM.

ICD-10-CM Structure: So how does ICD-10-CM differ from ICD-9-CM?

ICD-9-CM	ICD-10-CM
No Laterality	Laterality – Right or Left account for > 40% of codes
3-5 digits First digit is alpha (E or V) or numeric Digits 2-5 are numeric Decimal is placed after the third character	7 digits Digit 1 is alpha; Digit 2 is numeric Digits 3–7 are alpha or numeric Decimal is placed after the third character
No placeholder characters	"X" placeholders
14,000 codes	69,000 codes to better capture specificity
Limited Severity Parameters	Extensive Severity Parameters
Limited Combination Codes	Extensive Combination Codes to better capture complexity
1 type of Excludes Notes	2 types of Excludes Notes

Since ICD-10-CM is much more specific, more clinically accurate and uses a more logical structure than ICD-9, it is much easier to use than ICD-9-CM. However, going from 14,000 codes to 69,000 codes can have its own challenges. One ICD-9 code may have several corresponding ICD-10 codes. How would you know which code to use? Would a crosswalk from ICD-9 to ICD-10 codes be the logical way to go? Crosswalks are also known as General Equivalency Mappings (GEMs). The Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) created the GEMs as a tool for the conversion of data from ICD-9-CM to ICD-10-CM and ICD-10-PCS and vice versa. Although GEMs can be a good educational resource as they provide important information linking codes of one system with codes in the other system, they are not the most appropriate way to code patient encounters. Please click on the below link to find out more about the new features in ICD-10-CM which will make it inefficient to rely solely on GEMs for coding patient encounters.

ICD-10-CM Classification Enhancements

ICD-10-CM describes a medical diagnosis and must be elected based on clinical documentation. Selecting the appropriate ICD-10 code requires medical knowledge and familiarity with the specific clinical event. Even third-party billers cannot translate ICD-9 to ICD-10 codes unless they also have the detailed clinical documentation required to select the correct ICD-10 code.

The best way to code with ICD-10-CM would be through **Native Coding** which means to assign an ICD-10 diagnosis code directly based on clinical documentation. Practices are encouraged to natively code using ICD-10 code reference sources (code books or encoder systems). When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, coding should comply with the payer guidelines for the use of unspecified codes.

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In ICD-10 News: The Importance of Clinical Documentation

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Take Steps to Improve Your Clinical Documentation Now

One way to help your practice prepare for ICD-10 is to work on improving how you document your clinical services. This will help you and your coding staff become more accustomed to the specific, detailed clinical documentation needed to assign ICD-10 codes. All Healthcare Providers should be currently documenting most of the new definitions and concepts.

Take a look at documentation for the most often used codes in your practice; and work with your coding staff to determine if the documentation would be specific and detailed enough to select the best ICD-10 codes. For example, laterality is expanded in ICD-10-CM. Therefore, clinical documentation for diagnoses should include information on which side of the body is affected (i.e., right, left, or bilateral).

Remember, ICD-10 will not affect the way you provide patient care. It will just be important to make your documentation as detailed as possible since ICD-10 gives more specific choices for coding diagnoses. This information is likely already being shared by the patient during their visit—it's just a matter of recording it for your coding staff.

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Long Term Care Providers

Patient Liability Mass Adjustments

As a reminder, HP performs Patient Liability Mass adjustments the first claims processing cycle of each month. Patient liability changes within the clients' profile do not require claim adjustments to be performed by providers. Claims will be automatically adjusted by HP and the necessary A/R(s) and reimbursements will be generated. When a patient liability change is made by the Department of Social Services (DSS), all claims that are affected by that change will be identified and systematically adjusted the first cycle of the month following the update. For example, if your client's patient liability was adjusted on September 10th for the months of June through August, any paid claims for the months of June through August will be adjusted during the first cycle in October. To obtain the most recent claims processing cycle schedule, visit www.ctdssmap.com, click on Provider, then click on Provider Services, scroll down to "Schedules", and select the most current claims processing cycle schedule.

Claims impacted will appear on your remittance advice (RA) with an Internal Control Number (ICN) beginning with region code 53. If you were expecting a claim to be adjusted and the adjustment did not occur, please contact the Provider Assistance Center at 1-800-842-8440 to confirm that the patient liability amount has changed. If HP does not reflect the change in the system, please contact the regional worker and/or the district office to ensure the update was made.

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PES Users

Provider Electronic Solutions Upgrade/Changes

Provider Electronic Solutions (PES) will soon be upgraded to version 3.81. This upgrade introduces important changes to Long Term Care claim submission to accommodate the October 1, 2015 implementation of ICD-10. Long Term Care providers are encouraged to upgrade to this new version. Important: This upgrade also removes from PES the functionality to submit Professional, Dental, Inpatient, Outpatient, and Home Health claims and claim status transactions. Providers who upgrade to the 3.81 version will lose the ability to submit non-Long Term Care claims or claim status transactions. Providers who still use PES to submit these transactions are encouraged to transition to another claim submission/claim status method as these transactions will no longer be accepted via PES in the Fall of 2015.

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Dental Providers

Dental Code Compliance Changes

There have been several changes to the Medicaid Dental Services Fee Schedule and Policy with the effective dates of September 1, 2014 and October 1, 2014. Several dental codes have been added, removed or have been adjusted for reimbursement effective September 1, 2014. Please refer to the Medicaid Dental Services Fee Schedule to see these updates and to determine which services are restricted to which specialties and which require authorization. You may also access Provider Bulletin 2014-62 for these code updates and policy changes.

Beginning October 1, 2014 and forward, clients who reside in a long term care facility are now eligible for additional cleanings, fluoride treatments and examinations without requiring an authorization (twice yearly rather than once yearly, without prior authorization). PA requirements will be bypassed when the appropriate Facility Type Code (FTC) is used. Another policy change coming into effect October 1, 2014 includes dental code compliance updates. According to current policy regulations, the Connecticut Medical Assistance Program does not reimburse for the restoration of separate surfaces when treatment is performed on a single tooth by the same provider. ***Dental providers will be reimbursed for the total number of surfaces restored on a single tooth per one calendar year period for each provider.***

Effective October 1, 2014, claims will deny with either **Explanation of Benefit (EOB) code 0610 - Tooth number/tooth surface combination invalid or EOB 0266 - Insufficient number of valid tooth surface codes billed**. The following surfaces will be restricted to the following specified teeth:

Buccal (B): 1-32, A-T
Distal (D): 1-32, A-T
Facial (F): 1-32, A-T
Incisal (I): 6-11; 22-27; C-H and M-R
Lingual (L): 1-32, A-T
Mesial (M): 1-32, A-T
Occlusal (O): 1-5; 12-21; 28-32, A, B, I-L, S, T

Also, as a reminder, the dental fee schedule will only be available in the CSV format going forward.

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CHC Providers

Upcoming CHC Events

The Department of Social Services and HP will be making additional changes to the Connecticut Home Care Program, to assist the Access Agencies in uploading their care plans to the HP system. These changes will allow the Access Agencies to modify and upload care plans more quickly to the HP system, by eliminating the need for providers to void claims in order for the Access Agencies to make changes to the associated care plans. These system changes are currently scheduled for implementation in the fall of this year.

To prepare for these upcoming system changes and to ensure awareness and understanding of all program changes, including those made earlier in the year, HP will be offering CHC Service Provider and Home Health Agency refresher training. Providers should look for workshop invitations in the mail by early October. Should an invitation not be received, providers can review current Workshop offerings and sign up to attend a CHC Service Provider and/or Home Health Workshop by going to the Connecticut Medical Assistance Program Web site: www.ctdssmap.com. From this Web site Home page, click on Information > Publications > Forms > Provider Workshop Invitation Forms. Providers can also view workshop offerings, sign up to attend a workshop or view past workshop presentations from the www.ctdssmap.com Web site. Click on Provider Services > Provider Training > "here". Under Workshops, click on the workshop(s) you wish to attend. Under Materials, click on CHC or Home Health Workshop, then select the presentation you wish to view/download.

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Outpatient Hospitals

Multiple E/M Encounters on the Same Date

Outpatient hospitals can use modifier 27 "Multiple Outpatient Hospital E/M Encounters on the Same Date" to identify separate visits in the emergency department on the same day. For the second emergency room visit to be considered, the hospital would need to add modifier 27 to the emergency room Revenue Center Codes (RCCs) 450 and 456. Condition code G0 also needs to be added to the second encounter claim.

Claim Detail	DOS	RCC	Procedure Code	Mod	Units	Billed Amt	Paid Amt	Condition Code G0
Encounter 1								
1	6/1/2013	450	99283		1	$356.00	$156.82	N
2	6/1/2013	981	99283		1	$231.80	$91.07	N
Encounter 2								
1	6/1/2013	450	99283	27	1	$356.00	$156.82	Y
2	6/1/2013	981	99283	27	1	$231.80	$91.07	Y

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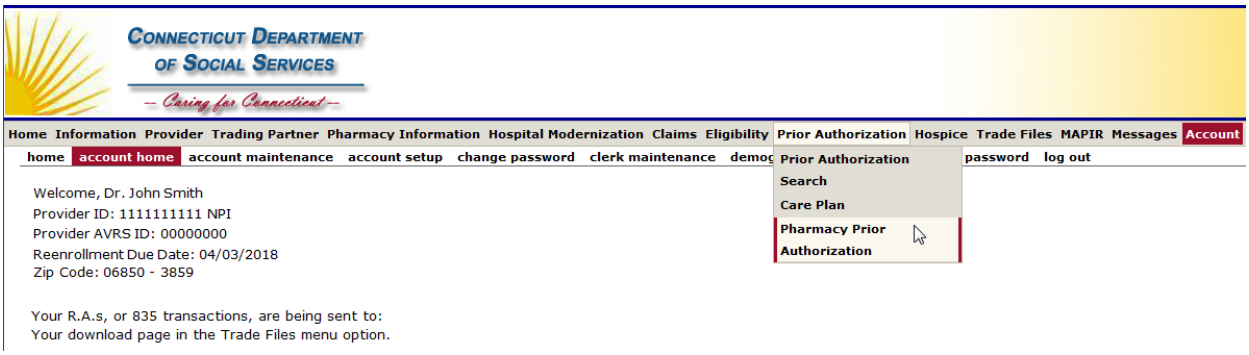
Prescribing Providers

Pharmacy Web Prior Authorization Is Here!

All enrolled prescribing providers are now able to utilize the Pharmacy Web Prior Authorization (PA) feature on the www.ctdssmap.com secure Web portal to:

- Submit Pharmacy PA requests including Brand Medically Necessary, Early Refill, Preferred Drug List, Optimal Dosage and Step Therapy.
- Upload additional supporting clinical documentation for PA requests.
- Receive PA number and decision status.
- Search and view previously submitted PA requests (prescribers will not be able to view authorization requests submitted by other practitioners).

The Pharmacy Web PA feature will simplify the prior authorization process and allow prescribing providers to request, track, and receive decision status of PA requests via the Web. The current method of pharmacy PA submission via fax will remain available to prescribers and will continue to be accepted by the Pharmacy Prior Authorization Call Center.



If you are an enrolled prescribing provider who has not yet received an access PIN to the www.ctdssmap.com secure Web portal via the mail, you should contact CTDSSMAP-ProviderEmail@hp.com and include your full name and NPI to request the access PIN.

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Organization and Group Providers

New Letter for Organizations/Groups when Members Added

Currently, when an organization/group adds/deletes a member via the "Maintain Organization Members" panel on the www.ctdssmap.com Secure Web portal, a letter is mailed to that member to inform them they have been added to/deleted from the organization/group. Many organizations/groups have requested that they receive a copy of this letter as a confirmation of the transaction. As a result of those requests, the organization/group will now also be mailed a letter when a member is added to/deleted from that organization/group via the Secure Web portal.

As a reminder, organizations/groups must use the "Maintain Organization Members" panel on the Secure Web portal to maintain organization/group member information. In addition to adding/deleting group members via this panel, this panel can also be used to view re-enrollment due dates of each member within that organization/group.

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Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
11/11/2014	Veterans Day	Open	Closed
11/27/2014	Thanksgiving	Closed	Closed
11/28/2014	Thanksgiving	Closed	Open
12/25/2014	Christmas Day	Closed	Closed

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Provider Bulletins

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

PB14-74 Tobacco Cessation Group Counseling at Hospital Outpatient Settings
PB14-73 Increase in Hospice Rates
PB14-72 Business Associate Agreement Between the Department of Social Services, Vendors and All CMAP Providers
PB14-70 Companion/Aide Authorization Requirement
PB14-69 Implementation of ACA 1104 Uniform Use of CARCs, RARCs and CAGCs on the X12 835 Health Care Claim Payment/Advice
PB14-68 Hospital Based Practitioners - Inpatient Services
PB14-67 Rescheduling of Hydrocodone Combination Products
PB14-67 Full Activation of Pharmacy and Non-Pharmacy OPR Edits
PB14-66 Addition of Influenza Vaccine (CPT 90688) to the Physician Office and Outpatient Fee Schedule
PB14-65 Private PRTF Per Diem Rates
PB14-64 New Prior Authorization Form for Step Therapy Additional Classes
PB14-62 Update to the Medicaid Dental Services Fee Schedule and Policy
PB14-61 Influenza Vaccinations Administered in Family Planning Clinics
PB14-60 Reimbursement for Practitioner Services Rendered in a Facility Setting
PB14-59 Urine Drug Screens Ordered by Methadone Clinics
PB14-58 Billing Guidance for Developmental and Behavior Health Screens in Primary Care
PB14-57 Prior Authorizations for Preventative Medicine and Evaluation and Management Visits Occurring on the Same Date of Service for Patients, 18-21 Years Old
PB14-56 Revisions to the Collaborative Agreement Requirement between Advanced Practice Registered Nurses and Clinical Providers
PB14-55 Pharmacy Web Prior Authorization
PB14-54 Add-on's to fees for extraordinary costs related to AIDS, maternal and child healthcare, Escort services, or extended hour services
PB14-53 Clarification to Policy Bulletin 14-47 "Interim Guidance Regarding Electronic Orders for MEDS Products"
PB14-52 Updated Provider Re-enrollment Notification and Process
PB14-51 Implementation of ACA 1104 Phase III Operating Rules - EFT and ERA Changes (Non-RX claims)
PB14-49 New CHC Respite PCA Service Procedure Codes

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Provider Bulletins

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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.

PB14-48 Enrollment Requirements for Residents
PB14-47 Interim Guidance Regarding Electronic Orders for MEDS Products
PB14-46 Expansion of Coverage For Over The Counter (OTC) Products
PB14-45 Connecticut Medical Assistance Program Provider Satisfaction Survey
PB14-44 Implementation of Connecticut General Statute 19a-492 Permitting Registered Nurses to Delegate Administration of Medication to Home Health Aides who have Obtained Certification for Medication Administration
PB14-43 Developmental and Behavioral Health Screens in Primary Care - Requirement of Modifiers
PB14-42 Private Non-Medical Institution (PNMI) Rates for Adult Mental Health Rehabilitation Services

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