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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
- Inpatient Hospital Payment Modernization DRG Calculator
- Are You Interested in Testing for ICD-10?
- Re-enrollment Reminder

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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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Inpatient Hospital Payment Modernization DRG Calculator

Effective with inpatient hospital admissions on or after January 1, 2015, the Department of Social Services (DSS) will implement a new APR DRG payment system. To assist hospital providers with predicting payment under this new payment system, a DRG Pricing Calculator has been implemented. This Pricing Calculator is located on the Hospital Modernization page of the www.ctdssmap.com Web site, under DRG Calculator. This spreadsheet allows calculation of payment for a single claim with the input of only a few data elements, such as the APR DRG code and the hospital's specific base rate. Providers will also have available from 3M Health Information Systems a tool to identify the appropriate APR DRG code.

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All Providers

Are you aware of the HUSKY Health Primary Care Increased Payments Policy for 2015?

As mandated under Section 1202 of the Affordable Care Act (ACA), Medicaid increased its payments to equal the 2013 and 2014 Medicare fee for certain primary care codes when billed by an eligible primary care provider, who has submitted a valid attestation to the Department of Social Services. **However, the ACA requirement ends with dates of service January 1, 2015 and forward.**

To continue these increased primary care payments and stay within Medicaid budget, the Department of Social Services has created a policy known as the HUSKY Health Primary Care Increased Payments Policy. The increased payments will be effective for dates of service **January 1, 2015 through June 30, 2015**. Continuation for the Primary Care Increased Payments Policy beyond June 30, 2015 is contingent upon whether funding is appropriated for State Fiscal Year 2016 by the General Assembly. The list of eligible codes for 2015 will be revised to specific services used routinely by primary care providers. The HUSKY Health Primary Care Increased Payments Policy Fee Table can be accessed from the www.ctdssmap.com Web site by going to "Provider", then to "Provider Fee Schedule Download". Click "I Accept" at the end of the Connecticut Provider Fee Schedule End User License Agreements and then click on "Fee Schedule Instructions" in red text at the top of the page. Scroll down to the HUSKY Health Primary Care Increased Payments Policy Fee Table.

Also, effective for dates of service January 1, 2015 through June 30, 2015, certain advanced practice registered nurses (APRN) practicing primary care may self-attest eligibility for primary care increased payments independent of a supervising physician attestation. Physicians and non-physician/midlevel practitioners who must attest eligibility for the first time under the HUSKY Health Primary Care Increased Payments Policy can access the following link starting January 1, 2015: https://www.surveymonkey.com/r/HUSKYHealthpcattest.

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Are You Interested in Testing for ICD-10?

October 1, 2015 is the new compliance date for health care providers and health plans to transition to ICD-10. HP encourages providers to beta test ICD-10 claims submission with us in order to prepare for the upcoming ICD-10 implementation. If you would like to become a beta tester, please contact the Connecticut Medical Assistance Program (CMAP) testing team. The testing requirements and process are described below:

1. Notify CMAP that you want to be a beta tester for IDC10 codes on 837 electronic claims
   a) E-mail to CTICD10testing@hp.com
   b) Title / Subject of email "ICD10 Testing"
   c) Include your Trading Partner ID, NPI, and AVRS ID for the claims you will be testing, your contact name and phone number, email address you wish the PDF remittance advice (RA) to be emailed to, and the type of claims (institutional/professional/dental) you will be testing
2. Prepare the 837 file
   a) Ensure ISA15 (test/ production indicator) is set to T for test
   b) Include no more than 25 claims
   c) Use ICD-10 codes for all diagnosis and surgical codes (if applicable)
   d) Dates of Service (DOS) 10/01/2014 forward; please do not submit any DOS beyond the current date on your claims

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All Providers

Are You Interested in Testing for ICD-10?

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3. Submit the file
   a) Submit to secure Web portal using the Trading Partner Web account
   b) Capture the tracking number after file is uploaded
4. Submit email notifying us a file has been sent
   a) Send email to CTICD10testing@hp.com
   b) Include the file tracking number and contact information
5. The file will be bounced against production client data and processed on the following Wednesday. The electronic file will be tested for HIPAA compliance. If compliant, the claims will be processed in our test system, allowing us to ensure the claims are adjudicating correctly. No 835 remittance advice (RA) will be produced for this activity. However, a PDF version of the paper RA is available upon request. To receive the PDF RA, ensure you send the email address where it is to be sent.

If the file is not compliant, HP will email you the ASC X12N 999 Implementation Acknowledgement for Health Care Insurance Transaction and our EDI staff will contact and inform you of the error and possible corrective action.

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Pharmacy Providers

Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients

The co-payment threshold for Low Income Subsidy/ Full Benefit Dual Eligible individuals is changing for 2015. Currently, the co-pay for generic drugs is $2.55 and the co-pay for all other drugs is $6.35. For dates of service of January 1, 2015 forward, the co-pay for generic drugs will be $2.65 and for all other drugs it will be $6.60.

Clients covered under a HUSKY Benefit Plan will continue to be responsible for the first $15.00 per month of their Medicare Part D co-pays (See note below). For a pharmacy or compound claim billed with Other Coverage Code of 8 and a Carrier Code of MDD (Medicare D co-pay-only claim), a co-pay will be applied until $15.00 has been charged to the patient.

In order to prevent the inappropriate use of the co-pay only transaction, a new edit is being implemented. This new edit will not allow a co-pay of greater than $6.60 to be billed to CMAP on or after January 1, 2015. The claim will deny and return the following message back to the pharmacy: "Co-pay only claim greater than $6.60 Not Allowed". If a claim is returned from the PDP with a co-pay of greater than $6.60, this issue must be resolved with the PDP.

Note: All Medicare Part D primary claims for clients who have Medicaid as a second payer must be submitted to HP Enterprise Services in order for the Department to track a client's $15.00 monthly co-pay responsibility. Submitting all Medicare Part D claims will allow the client's co-pays to systematically accrue to include prescriptions processed by another pharmacy or the reversal of a previously paid claim.

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DME Providers

Clarification of Durable Medical Equipment (DME) Rental Periods and Rent to Purchase Guidelines

Many providers have been asking questions regarding what is the standard rental period for DME and also what to do if they submit a claim for a rental and then purchase the equipment. Providers have also questioned what happens when that rental payment hasn't been deducted from the purchase automatically.

The initial period for the rental of DME is determined by the Department of Social Services (DSS). Many items on the Connecticut Medical Assistance Program (CMAP) DME fee Schedule have a three (3) month rental period; anything beyond that would require a Prior Authorization from Community Health Network (CHN) to continue the rental or would need to be purchased. DSS expects that items are rented for the initial three (3) months and then subsequently purchased. The purchase price of the equipment should be reduced by the amount DSS has paid for the rental, when the equipment that is rented is then subsequently purchased. The Department of Social Services expects that the provider will submit a refund for claims when the system fails to deduct the rental payment from the purchase payment of the equipment. If this is the case, the provider should adjust their claim and deduct the initial rental payment amount from the purchase price of the equipment.

To access the DME Fee Schedule, go to www.ctdssmap.com. From this Web page, go to "Provider" then to "Provider Fee Schedule Download", click "I Accept", and then scroll down to "MEDS – DME" or the applicable MEDS fee schedule.

For more information regarding DME billing and rental periods, please refer to CHN's Web site www.huskyhealthct.org/providers.html.

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Connecticut Home Care Providers

The Importance of Checking your Service Authorizations (PAs) via your Connecticut Medical Assistance Secure Web Account before submitting claims

Recent program changes now allow the Access Agencies to upload changes to a PA, which may end date a PA, add units, and change frequency type and number without requesting the CHC provider recoup the claims paid against the PA. As a result of these changes, HP will begin reprocessing previously paid claims that have been impacted by the PA changes made by the Access Agencies on an ongoing basis.

The first reprocessing of these paid claims, scheduled for the first cycle in December, for PA changes made October 29, 2014 through October 31, 2014 has been delayed. Paid or partially paid claims impacted by changes made by the Access Agencies from October 29, 2014 through October 31, 2014 will now be reprocessed in the first cycle of January, 2015 and claims impacted by changes made by the Access Agencies in November, 2014 will be reprocessed in the first cycle of February, 2015. Thereafter, claims impacted by changes made to PAs in the months to follow, will be reprocessed in the first cycle of the month, two months after a PA is changed by the Access Agency, unless otherwise communicated to providers.

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Connecticut Home Care Providers

The Importance of Checking your Service Authorizations (PAs) via your Connecticut Medical Assistance Secure Web Account before submitting claims

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As changes made to a PA by the Access Agency are immediate, provider PAs may show negative units, be end dated with no resuming PA, or be ended with a resuming PA that is not of the same service code/modifier previously paid on the claim. As a result, providers are encouraged to review all PAs for clients for whom they are expecting to receive updated service authorizations. Checking service orders applicable to the claims being submitted will avoid unexpected claim denials or a cutback of units due to the PA changes made by the Access Agencies. PA discrepancies which cause denial or unit cutback should be referred to the Access Agencies using the contact information located in the "Welcome to the Connecticut Home Care Program Implementation" Important Message on the www.ctdssmap.com Home page.

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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 are beginning to reach 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 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.

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Appendix

Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
12/25/2014	Christmas Day	Closed	Closed
12/26/2014	Day After Christmas	Open	Open
1/1/2015	New Year's Day	Closed	Closed
1/19/2015	Martin Luther King 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.

PB14-86 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)

PB14-86 January 1, 2015 Changes to the Connecticut Medicaid Preferred Drug List (PDL)

PB14-86 Reminder About the 5 day Emergency Supply

PB14-85 Rate for Live-in Personal Care Assistant Service

PB14-84 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health, Charter Oak, and CADAP Programs)

PB14-83 New Hepatitis C Prior Authorization Criteria - Sovaldi

PB14-82 Rate Increase for Home Health Agencies

PB14-81 Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients

PB14-80 Primary Diagnosis Coding Instructions and Hospice's Notice of Election (NOE) Filing

PB14-79 Inpatient Hospital Payment Modernization/All Patient Refined-Diagnostic Related Group (APR-DRG)

PB14-78 Funding for State-Funded Coverage for Independent Chiropractic Services for Adults Has Ended for State Fiscal Year 2015 (SFY2015)

PB14-77 Mileage Reimbursement for Homemakers and Companions Transporting Clients to Medical Appointments

PB14-76 Increasing the Reimbursement Rate for Paragard - HCPCS J7300

PB14-75 HUSKY Health Primary Care Increased Payments Policy

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