December 2017
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

# Provider Quarterly Newsletter

## New in This Newsletter

- All Providers: Request for Assistance in Obtaining Payment when a Primary Carrier Fails to Pay or Respond to the Provider's Claim
- Primary Care Providers: Understanding Your Professional Enhanced Rate Reimbursement
- All Providers: Social Security Number Removal Initiative (SSNRI)
- Hospice Providers: Hospice Forms
- All Providers: Eligibility Response Quick Reference Guide
- CHC, ABI, PCA & Home Health Care Providers: Electronic Visit Verification (EVV) Program Updates
- All Providers: Train Your New Office Staff
- All Providers: Provider/Type/Specialty/Taxonomy Crosswalk
- Autism Waiver Services Providers: Importance of New Program Training

# Table of Contents

# Request for Assistance in Obtaining Payment when A Primary Carrier Fails to Pay or Respond to the Provider's Claim

- In cases where the primary insurance to Medicaid is denying the claim due to not receiving information from the client, the providers can submit the claim denials to Medicaid for processing with the appropriate Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) from the primary carrier.

- In cases where the primary insurance to Medicaid is not responding to the claim due to not receiving information from the client, the provider should use the Legal Notice of Subrogation Form (W-81) when initially pursuing commercial health insurance. This puts the insurance company on legal notice that it must make any payment for which it is liable directly to the provider.

- If the provider does not receive payment within forty five (45) days from the date on the Legal Notice of Subrogation Form, they should fully document that every reasonable attempt was made to receive payment. The provider must file a request for assistance with the Connecticut Department of Insurance using form W-82, Request for Assistance in Obtaining Payments. The Department of Insurance will furnish the hospital with a file/case number.

- The Department of Social Services (DSS) is aware that other insurance carriers never cover some services. In addition, there are some insurance companies that do not provide an actual denial statement or, in some cases, never respond to written requests. To address these problems and to alleviate any unnecessary burden on the provider, DSS implemented the Third Party Billing Attempt Form (W-1417). This form documents that the hospital has made every attempt to obtain payment from the other insurance carrier prior to claim submission to the Connecticut Medical Assistance Program (CMAP). The form may be used in place of a denial voucher for the other insurance carrier, but may not be used in place of a Medicare denial. If the provider has not received any insurance payment within ninety (90) days of the date of the initial claims submission, then the provider may bill the Connecticut Medical Assistance Program. The Department of Insurance file/case number is required on the W-1417 form. Failure to include the Department of Insurance file/claim number will result in the claim being returned to the provider.

These instructions can be found under Provider Manual Chapter 5 "Claim Submission Information" on the www.ctdssmap.com Web site. The forms can be downloaded from the www.ctdssmap.com Web site, under Information and then Publications and scrolling down to Third Party Liability Forms.

Back to Table of Contents

# Understanding Your Professional Enhanced Rate Reimbursement

One of the questions we hear frequently from our primary care providers is "How do I calculate my enhanced payment for a specific service?" There are two enhanced payment programs that primary care providers are eligible to participate in – the HUSKY Health Primary Care and the Person Centered Medical Home (PCMH) program. Since providers can be eligible for both enhanced payment programs, the following guide to calculating the enhanced payment should shed some light on the reimbursement amounts that appear on the Remittance Advice.

HUSKY Health Primary Care Increased Payments

To find the Primary Care Increased Payment Policy Rate, you must access the HUSKY Health Primary Care Increased Payments Policy Fee Table from the www.ctdssmap.com Web site. It is located under "Provider" → "Provider Fee Schedule Download". You must click "I Accept" at the end of the Connecticut Provider Fee Schedule End User License Agreements. The rates are located in the Fee Schedule Instructions document in the red text at the top of the page. Once you open the document, simply scroll down to "Table 4-HUSKY Health Primary Care Increased Payments Policy Fee Table".

The rates are divided into facility and non-facility rates and are payable based on the eligibility of the individual performing provider and NOT the group.

PCMH

The PCMH rate is an add-on (percentage based) rate that varies depending on the level of PCMH recognition. The percentage increase applies to the PCMH specific Primary Care Codes based on CT Medicaid fee-for-service base rates found on the provider's fee schedule. The percentages applied are 12%, 20% and 24% and correspond to the Glide Path, NCQA Level 2 and NCQA Level 3 recognition.

To calculate the appropriate reimbursement, the provider must know the recognition level of the billing practice on the date of service of the claim. The reimbursement is calculated by multiplying the CT Medicaid fee-for-service rate found on the provider's fee schedule by the appropriate percentage. (The Fee Schedule Instructions document can be used to further clarify the various rate types used on "Physician Office and Output Services" fee schedule.) The resulting amount is then added to the CT Medicaid fee-for-service rate or the Primary Increased Payment Policy Rate if appropriate.

Relevant Explanation of Benefit (EOB) Codes

The following EOB codes will post to the claim detail if one or both of the enhanced rates has been applied:

**EOB code 9964** PRICING ADJUSTMENT - ACA MAX FEE PRICING APPLIED

**EOB code 9965** ACA ENHANCED RATE ADD ON

(continued on page 3)

Back to Table of Contents

(Continued from page 2)

**EOB code 9975** PCMH percentage rate applied

**EOB code 9972** PCMH pricing adjustment when a partial or no percentage rate applied

The following EOBs posted to a claim detail submitted by a pediatric provider with CPT 99213, non-facility place of service and DOS of April 2017. The billing provider in the example has PCMH NCQA Level 3 recognition which corresponds to a 24% add-on payment. The EOBs indicate that both the PCMH and ACA rates were applied. The detail reimbursed at $92.49 and the PED rate was used in the calculations below:

| Detail Number | EOB Code | EOB Description |
|---|---|---|
| 0 | 9997 | REFER TO DETAIL EOB |
| 1 | 9975 | PRICING ADJUSTMENT - PCMH PERCENTAGE RATE APPLIED |
| 1 | 9964 | PRICING ADJUSTMENT - ACA MAX FEE PRICING APPLIED |
| 1 | 9965 | ACA ENHANCED RATE ADD ON |

$79.19 (Non-Facility HUSKY Health Primary Care Rate 01/01/15—08/10/17)

$55.41 (Non-Facility Pediatric Physician Rate)

24% (PCMH add-on)

**FINAL REIMBURSEMENT CALCULATION:** ($55.41 x 24%) + $79.19 = $92.49

Back to Table of Contents

# All Providers

## Social Security Number Removal Initiative (SSNRI)

Medicare is taking steps to remove the Social Security based numbers from Medicare cards in an effort to prevent fraud, fight identity theft and protect essential program funding and the private healthcare and financial information of our Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) will issue new Medicare cards with a new unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI) to replace the existing Social Security-based Health Insurance Claim Number (HICN) both on the cards and in various CMS systems currently being used. CMS will start mailing new cards to people with Medicare benefits in April 2018, and all Medicare cards will be replaced by April 2019.

Your current systems will need to be able to accept the new MBI format by April 2018. You will be able to bill and file healthcare claims to Medicare using a patient's HICN during the transition period, however CMS encourages you to work with your billing vendor to make sure that your system will be updated to reflect these changes as well.

CMS offers 5 steps you can take today to help your office or healthcare facility get ready:

1. Go to the CMS provider Web site and sign-up for the weekly MLN Connects® newsletter.

2. Attend CMS quarterly calls to get more information. Upcoming calls will be scheduled in the MLN Connects® newsletter.

(Continued on Page 4)

Back to Table of Contents

(Continued from Page 3)

3. Verify all of your Medicare patients' addresses. If the addresses you have on file are different than the Medicare address you get on electronic eligibility transactions, ask your patients to contact Social Security and update their Medicare records.

4. Work with CMS to help your Medicare patients adjust to their new Medicare card. When available, later this year, you can display helpful information about the new Medicare cards. Hang posters about the change in your offices to help spread the word.

Test your system changes and work with your billing office staff to be sure your office is ready to use the new MBI format.
To learn more, visit: www.cms.gov/Medicare/SSNRI/Providers/Providers.html

Back to Table of Contents

# Hospice Providers

## Hospice Forms

DXC Technology has been informed by the Department of Social Services (DSS) that there has been an influx of the discharge Hospice form(s) faxed to DSS for discharge reasons other than "just cause". As a reminder, completed discharge forms should not be faxed to DSS, **except** when the client is being discharged for the reason "just cause". In addition, providers should not fax any other Hospice form(s) to DSS, instead they must be retained at the provider's office in the client's file and available for DSS' review upon request.

Paper versions of the hospice forms can be downloaded from the www.ctdssmap.com Web site. From the Home page, select "Information", "Publications", and then scroll down to "Hospice Forms". Here you will find the appropriate form(s) for all hospice transactions.

Providers are urged to reference and carefully review the online step by step instructions guide titled "Instructions for Submitting Hospice Transactions", available as a "quick link" directly above the online "Hospice Request Form", once logged into your secure Web portal and/or "Provider Specific Claims Submission Instructions", Chapter 8 Hospice. Both of these resources will provide you with clarity on the requirements for all hospice transactions.

Back to Table of Contents

# All Providers

## Eligibility Response Quick Reference Guide

Providers verifying eligibility on the www.ctdssmap.com Web site can find additional information about the eligibility verification request responses that may be received. To access this additional information, go to Information, then Publications, then scroll down to the second to last panel, "Claims Processing Information", and click on the Eligibility Response Quick Reference Guide link.

Back to Table of Contents

# CHC, ABI, PCA & Home Health Care Providers

## Electronic Visit Verification (EVV): Program Updates

Based on provider feedback, DSS continues to improve the EVV program and the provider experience. The following are EVV program enhancements all providers can look forward to.

**Implemented Enhancements**

At Your Fingertips tip sheet - "At Your Fingertips" is a bi-monthly tip sheet designed to help providers navigate EVV by answering common questions and providing assistance for resolving common issues encountered during a provider's use of the EVV system. The tip topics are generated by questions submitted to Sandata Customer Care, to the EVV email box ctevv@dxc.com, or in communications to DSS for assistance. Suggestions for future tip sheet topics can be sent to the EVV email box, ctevv@dxc.com.

New Service Codes Added to Santrax – The following procedure codes and Revenue Center Codes (RCC) will be added to the Sandata portal and mandated for use effective 1/1/18.

- G0162 - HHC registered nurse for management and evaluation of poc, 15 min
- G0151 - Physical therapy in the home health/ hospice setting
- G0152 – Occupational therapy in the home health/ hospice setting
- G0153 – Speech language therapy in the home health/ hospice setting
- RCC 424 – Physical Therapy Evaluation
- RCC 434 – Occupational Therapy Evaluation
- RCC 444 – Speech Therapy Evaluation

A provider bulletin will be published with additional information soon.

**Future Enhancements**: The following enhancements are not available to providers at the time of this printing. Providers will be made aware when these enhancements can be utilized.

Alternate Claim solution - While many providers benefitted from the Santrax claim submission

(Continued on Page 6)

Back to Table of Contents

(Continued from Page 5)

feature, feedback received has indicated that some providers prefer to submit claims directly to DXC Technology from their own claim submission software. In the near future, DSS will be implementing an alternate claims solution for EVV mandated providers. Providers will be allowed to submit claims outside of the Santrax system.

Removal of Other; Documentation Provided - Among the list of Schedule Edit/ Alteration Reasons Justifications was the option, Other; Documentation Provided. This reason code will be removed and replaced with a more specific schedule edit reason code that accurately describes why a scheduled visit was modified. Providers were invited to suggest replacement reason codes. When the new replacement code(s) is determined, it will be incorporated into Santrax and providers will be notified.

Removal of Middle Call in Back to Back Services – Providers have communicated that some caregivers experience difficulty in using the three call method for back-to-back services. As a result, the second call that serves as a check-out for the first call and a check-in for the second call will not be necessary and caregivers will utilize one check-in and one check-out for all consecutively scheduled and performed services.

Adding a new client to the system – At the current time, providers are unable to schedule clients who are present in their Santrax system due to lack of eligibility or prior authorization. A Santrax system enhancement will be made available to providers in the future that will allow providers to set up new clients who have not been uploaded into Santrax. Providers will be able to enter some client demographic information, create a schedule and to perform visit maintenance while they wait for the client information to be uploaded into Santrax.

Back to Table of Contents

# CHC, ABI, PCA & Home Health Care Providers

## Electronic Visit Verification (EVV): Who to Contact for Assistance

Electronic Visit Verification (EVV) mandated providers may have questions about who to contact regarding EVV related issues. **If, after reviewing the contact information below you are unsure who to contact for assistance, please send an e-mail to ctevv@dxc.com and your email will be routed to the appropriate party.**

**Please do not email client identifying data in your email unless you encrypt your e-mail.**

**Missing Client:** If you are missing a client from your Santrax system and have verified that the client has an approved prior authorization (PA) assigned to your agency and is currently eligible on their waiver benefit plan, please contact DXC Tech-

(Continued on Page 7)

Back to Table of Contents

(Continued from Page 6)

nology at ctevv@dxc.com. DXC Technology will research the client(s) and advise any next steps.

**Missing/Incorrect Prior Authorization:** If a prior authorization (PA) is present on the www.ctdssmap.com portal but is not present in the Santrax system, please send an email to ctevv@dxc.com with the PA number. DXC Technology will research the PA and advise any next steps. If the PA on the DSS portal does not reflect your verbal PA or the service order provided by an Access Agency, please contact the client's Access Agency for assistance. Please note: A prior authorization must be in an ***approved*** status in order to be uploaded to the Santrax system.

For additional information, please see the Important Message titled, "How to Resolve Unexpected Clients in Your Santrax System", found on the Connecticut Medical Assistance Program (CMAP) Web site Home page at www.ctdssmap.com.

**Changes to Client Phone Number:** All updates to the client's home telephone number must be requested by the client or client representative by contacting the DSS Benefit Center at 1-855-626-6632. While the home telephone number is being updated, please utilize the three (3) additional telephone lines in Santrax to record alternate phone numbers for the client. These alternate phone numbers can be used to validate visit data and reduce the number of exceptions due to the use of unknown phone numbers during a telephony check-in or check-out.

**Changes to Client Address:** Corrections to a client's primary address in Santrax should be communicated to the Access Agency responsible for managing the client's care plan. The Access Agency will request the necessary address corrections from DSS. While the address field is being updated, please utilize the additional address fields to store alternate addresses for the client. The additional addresses entered into Santrax must be frequent addresses for the client, such as a work address or a family member's address. These alternate addresses can be used to validate visit data and reduce the number of exceptions due to invalid GPS locations used in a check-in or check-out.

**Santrax System Issue:** Please contact Sandata Customer Care if you are experiencing issues with the Santrax system and its functionality. They can be reached at 1-855-399-8050 or by email at ctcustomercare@sandata.com.

Back to Table of Contents

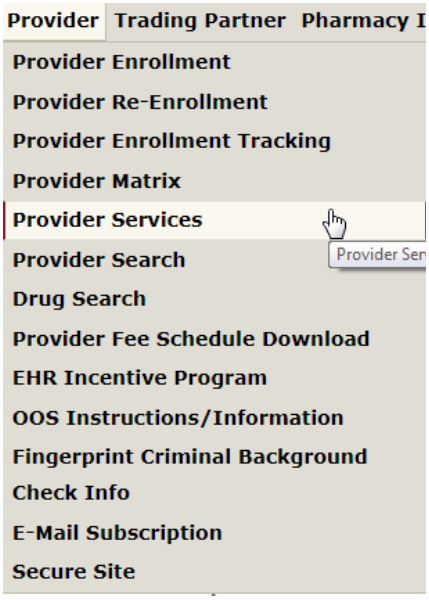
# All Providers

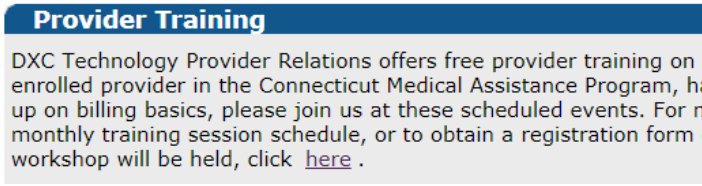
## Train Your New Office Staff

Do you have a new office staff member? Are you struggling to educate them on how to use the Connecticut Medical Assistance Program (CMAP) Web site? Did you know that DSS has made training materials available to you on the CMAP Web page?

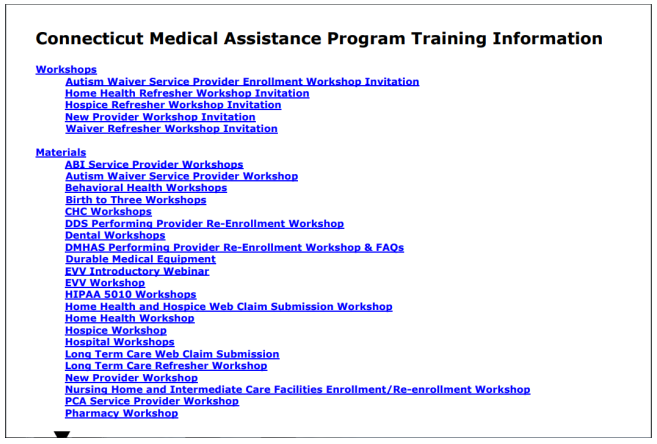
All previously conducted new provider and refresher trainings workshops are available on the CMAP Web site (www.ctdssmap.com). The trainings are categorized by provider type and cover many topics including verifying eligibility, researching prior authorization, and how to use the CMAP Web portal to submit claims.

To access the training slide decks from the CMAP Web page, select Provider > Provider Services > and then, at the bottom of the page, select Provider Training > click "here".




When the page loads, you will see a list of current workshop invitations and a list of previous workshops organized by provider type. When you make a selection, you will be presented with the invitation or the workshop presentation.




These training slide decks are beneficial to all office staff who use the CMAP Web page in the performance of their job.

Back to Table of Contents

# All Providers

## Provider Type/Specialty/Taxonomy Crosswalk Updated

An updated version of the Provider Type/ Specialty/Taxonomy Crosswalk has been added to the www.ctdssmap.com Web site under Information, Publications page, under Forms, Provider Enrollment/ Maintenance Forms. This can also be found on the Trading Partner tab under EDI at the bottom of page under Miscellaneous. The update is for September 25, 2017 and forward. This is a very useful document when a Provider Type, Specialty or Taxonomy inquiry is needed. There is also useful information on what types of forms are to be used for billing UB-04 claims, CMS-1500 claims, etc. If there is an asterisk* next to the provider type it indicates this type/specialty/ taxonomy combination is not currently used. A double asterisk** indicates that this type/ specialty/taxonomy combination was formerly applicable to Managed Care Organizations (MCOs).

# Providers of Autism Waiver Services

## Importance of New Program Training

Are you aware of the upcoming changes occurring to the Autism Waiver Program effective for dates of service January 1, 2018?

Here is what you should know and do before January 1, 2018 so as not to delay reimbursement for the services you may provide to Autism Waiver clients on or after January 1, 2018:

Providers (both individual practitioners and organizations) of Autism Waiver Services must be enrolled as an Autism Waiver Service provider to be reimbursed for the services they provide on or after January 1, 2018.

If you did not attend one of the Autism Waiver Service Provider Enrollment Workshops offered in October 2017, a copy of the presentation is available on the www.ctdssmap.com Web site. From the Home page, select provider > provider services > provider training > click on the “here” link at the end of the paragraph. The training page window will open. Under “Materials”, select “Autism Waiver Service Provider Workshops” then select the “Autism Waiver Service Provider Enrollment Workshop”.

If you have not yet enrolled, review the workshop presentation before you begin the enrollment process for important information and helpful hints in

(Continued on Page 10)

Back to Table of Contents

(Continued from Page 9)

completing the online application, tracking your completed application and what to do upon notification of enrollment or denial status.

Enroll as an "Autism Waiver Service Provider" as soon as possible, if you intend on continuing to service Autism Waiver clients on or after January 1, 2018. Please note that the enrollment process can take up to four to six weeks or more to be finalized.

**Effective for dates of service January 1, 2018, providers of Autism Waiver Services must submit claims for the Autism Waiver Services they provide to Autism Waiver clients.**

If you did not attend one of the Autism Waiver Service Provider Billing and Web Claim Submission Workshops offered in late November or early December 2017, a copy of the presentation is available on the www.ctdssmap.com Web site. From the Home page, select provider > provider services > provider training > click on the "here" link at the end of the paragraph. The training page window will open. Under "Materials", select "Autism Waiver Service Provider Workshops" then select the "Autism Waiver Service Provider Billing and Web Claim Submission Workshop".

The Autism Waiver Service Billing Provider Workshop reviews:

The Set-up of your secure Web account and secure Web account capabilities including:

- Client eligibility and how you can verify that a client has an Autism Waiver Benefit Plan on their eligibility file
- The importance of Care plan review and how to verify a) a Care Plan has been set up online for the client and b) the Autism Waiver services to be provided are on the Care Plan
- Web claim submission and benefits of submitting claims via the Web.

Providers of non-medical Autism Waiver services are encouraged to review the Billing and Web Claim Submission Workshop to ensure their readiness to submit claims for services provided January 1, 2018 and forward, and to maximize their reimbursement for the services provided in a timely manner.

Back to Table of Contents

# Appendix

## Holiday Schedule

| Date | Holiday | DXC Technology | CT Department of Social Services |
|---|---|---|---|
| 12/25/17 | Christmas | Closed | Closed |
| 1/1/18 | New Year's Day | Closed | Closed |
| 1/15/18 | Martin Luther King Jr. Day | Closed | Closed |
| 2/12/18 | Lincoln's Birthday, observed | Open | Closed |
| 2/19/18 | President's Day | Closed | Closed |
| 3/30/18 | Good Friday | Closed | 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.

PB17-83 Important Changes to Billing Instructions For Home Health Nursing Evaluation and Therapy Services for CHC, ABI and PCA Waiver Members

PB17-76 2018 HIPAA-Compliant Updates to the Freestanding Ambulatory Surgical Center Fee Schedule

PB17-75 New Clinical Guidelines—Prior Authorization (PA) Whole Exome and Whole Genome Sequencing

PB17-74 Reminder About the 5 day Emergency Supply

PB17-74 January 1, 2018 Changes to the CT Medicaid Preferred Drug List (PDL)

PB17-74 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)

PB17-73 Electronic Visit Verification (EVV) New Schedule Edit Reason Code

PB17-72 Revision to the HUSKY Health Primary Care Increased Payments Policy

PB17-71 Nusinersen Coverage Guidelines—Revised to Include a Prior Authorization Process for Outpatient Hospitals

PB17-70 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health and CADAP Programs)

PB17-69 National Correct Coding—Medically Unlikely Edits Review Process

PB17-68 Updated Guidance Regarding Multi-disciplinary Examinations

PB17-67 Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients

PB17-66 Electronic Visit Verification (EVV) Compliance

PB17-65 Claims Submitted with Facility Type Code/Place Of Service 19 under the HUSKY Health Primary Care Increased Payment Policy

PB17-64 New Clinical Guidelines—Prior Authorization (PA) Electric Tumor Treatment Field Therapy

PB17-63 Important Autism Waiver Provider Enrollment And Claim Submission Changes for Providers Of Autism Waiver Services under the Autism Waiver Program

PB17-62 Reminder to Access Agencies on Use of Pro-Rated Service Codes

PB17-61 Hospice Rates for Federal Year 2018

PB17-60 Increased Rate for Nursing Services for Complex/High Tech Level of Care

PB17-59 Clarifying Billing Instructions for Therapy Evaluations and Services Performed as Part of the Home Health Care Plans (Revised)

PB17-58 Provider Satisfaction Survey

PB17-57 Revision to the Code Group List Used to Obtain Prior Authorization under HUSKY Plus

PB17-56 Authorization for Palivizumag (Synagis) 2017-2018 Respiratory Syncytial Virus (RSV) Season

PB17-55 Early Intervention Services Pursuant to EPSDT Coverage and Reimbursement under The CT Medical Assistance Program (CMAP) Revised

PB17-54 Reasons of Medical Necessity for Dental Periapical Imaging

PB17-53 Partial Hospitalization Program

What regular feature articles would you like to see in the newsletter? We would like to hear from you!!

CTDSSMAP-ProviderEmail@dxc.com

Back to Table of Contents

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