June 2018
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- All Providers: Web Enhancement Provider Controlled Password Reset Capability
- ABI, Autism, CHC and PCA Waiver Clients: Timely Resolution of Prior Authorization Issues
- Home Health, ABI, Autism, CHC and PCA Waiver Clients: Waiver Crosswalk Updates
- EHR Eligible Providers: Electronic Health Records (EHR) Incentive Program Important Messages Archives

Table of Contents

Acquired Brain Injury (ABI), Connecticut Home Care Program for Elders (CHC), Personal Care Assistance (PCA) and Home Health Service Providers

Electronic Visit Verification (EVV) Enhancement — Alternate Claim Solution..... Page 1

All Providers

Web Enhancement Provider Controlled Password Reset Capability ..... Page 3

Acquired Brain Injury (ABI), Connecticut Home Care Program for Elders (CHC), Personal Care Assistance (PCA) and Home Health Service Providers

Timely Resolution of Prior Authorization Issues..... Page 4

Home Health, Acquired Brain Injury (ABI), Connecticut Home Care (CHC), and Personal Care Assistance (PCA) Waiver Service Providers

Updated Procedure Code Crosswalks for the ABI, Autism, CHC and PCA Waiver Programs..... Page 5

All Providers

Provider Manual Overview..... Page 7

Acquired Brain Injury (ABI), Connecticut Home Care Program for Elders (CHC), Personal Care Assistance (PCA) and Home Health Service Providers

Electronic Visit Verification—At Your Fingertips..... Page 9

All Providers

Social Security Number Removal Initiative (SSNRI) Update..... Page 9

EHR Eligible Providers

Electronic Health Records (EHR) Incentive Program Important Messages Archives..... Page 10

Appendix

Holiday Schedule..... Page 11

Provider Bulletins.....Page 12

Acquired Brain Injury (ABI), Connecticut Home Care Program for Elders (CHC), Personal Care Assistance (PCA) and Home Health Service Providers

Electronic Visit Verification (EVV) Enhancement — Alternate Claim Solution

On April 11, 2018, the Department of Social Services (DSS) implemented an alternate claim solution which allows providers who submit claims via the Santrax EVV system to bill or adjust claims with a date of service on or after January 1, 2018 using any of the following options:

- provider's own billing system;
- www.ctdssmap.com secure Web site;
- Santrax system; or

any combination of these three methods.

This article will provide a brief overview of the alternate claim solution. For more information, providers should reference provider bulletin PB18-17 Electronic Visit Verification (EVV) Enhancement – Alternate Claim Solution.

What should I know about the Alternate Claim Solution?

1. EVV mandated services that are submitted outside of Santrax are subject to the same visit validation requirements as claims exported from Santrax.
2. The alternate claim solution does not remove the requirement that providers use the Santrax system to create schedules, check-in/out or confirm visits and does not change the EVV compliance requirement. Providers are still expected to achieve a minimum 90% compliance rate in their use of the EVV system.
3. A claim submitted for payment outside of Santrax must have a matching *confirmed* visit in Santrax that contains the same data. The confirmed visit must contain the same client ID, provider ID, date of service, service code and modifier(s).
4. It takes up to 24 hours for the confirmed visit data in Santrax to become available to DXC Technology for claims processing. It is critical to ensure visits are confirmed in a timely manner, at least 24 hours prior to claim submission, in order to avoid unnecessary claim denials.
5. If units on an authorization are increased or a PA is added to the Santrax system after a visit has been confirmed, the visit must be refreshed and updated in Santrax to reflect an accurate number of confirmed units. Failure to refresh the Santrax system prior to claim submittal could result in a claim denial even if a PA is present on DXC Technology's portal because it has not been linked to the visit in Santrax. Instructions on refreshing the Santrax system can be found on the At Your Fingertip #16, titled Alternate Claim Solution Explanation of Benefit Codes located on the EVV Important Message.

What should I know about the new EOB codes?

With the implementation of the alternate claim solution, explanation of benefit (EOB) code 630 – "Claim must be submitted via EVV system" will no longer post on EVV claims with a date of service on

(continued on page 2)

Back to Table of Contents

(continued from page 1)

or after January 1, 2018 that are billed to DXC Technology outside of the Santrax system. Four (4) new EOB codes have been introduced and will set as described below.

- *EOB code 3327 "Confirmed visit not found"* - This EOB code will post to a claim if there is no confirmed visit found in Santrax that contains matching visit data. To resolve this claim denial, a matching visit must first be confirmed in the provider's Santrax system.
- *EOB code 3328 "Confirmed visit units are exhausted"* - This EOB code will post to a claim containing an EVV mandated service where there is a confirmed visit that matches the claim data, however, the visit units have been exhausted due to a previously paid claim. This claim denial can only be resolved if the confirmed visit units in Santrax are sufficiently increased.
- *EOB code 0047 "Confirmed visit units are exceeded"* - This EOB code will post to a claim containing an EVV mandated service where the confirmed data in Santrax matches the claim data, however, the visit units on the confirmed visit are less than the units billed on the claim. This claim will pay, but it will cut back to the number of units on the confirmed visit. This EOB can only be resolved if the confirmed visit units in Santrax are sufficiently increased.
- EOB code 0047 may also occur if there are two visits for the same client and service on the same day and only one visit is confirmed. The second visit must be confirmed in order for the claim to pay the total number of units billed for the day.
- *EOB code 3329 "Detail dates of service that span 31 days cannot be verified"* - Claims submitted from Santrax are limited to one date of service per claim detail. Claims submitted outside of Santrax may be submitted using spanned dates. These spanned dates cannot exceed 31 days. This denial is resolved by reducing the number of days submitted on the claim detail.

For more information on the alternate claim solution, please contact the EVV mailbox at ctevv@dxc.com.

Back to Table of Contents

Attention All Providers

Web Enhancement Provider Controlled Password Reset Capability

Web Enhancement Provider Controlled Password Reset Capability

Have you ever forgotten your password to the Secure Web site? It happens to the best of us! The good news is that as of June 27, 2018, master users AND clerks will have the ability to more easily reset their password via the web.

As we implement this new functionality, providers and trading partners, as well as their associated clerks, will be prompted to create two (2) security questions and answers during their next log in to the Secure Web site. The newly collected questions and answers will replace any currently stored data and can contain upper and lower case letters, as well as alphanumeric characters. Blank spaces are also permitted as well as a question marks (?), however, no other special characters can be used in either the question or the answer. The user entering this information will also have to supply a valid email address.

Once these security question requirements are met, the Web portal account user will have access to the following self-service functionalities:

- Reset password
- Unlock account
- Reactivate account in the instance that it has not been logged into in over 90 days.

Updated messages on the Secure Web portal will direct master users and clerks to use the password reset self-service functionality. Master users should only contact the Provider Assistance Center for help if messages indicate that an account is in a locked/disabled status where there is no longer any self-service functionality available. Clerks must continue to contact the master user for their organization in these instances. If a clerk does not know who the master user is for their organization, they should contact the Provider Assistance Center.

Additional information on Secure Web portal enrollment and account maintenance can be found by accessing Chapter 10 from the Information > Publications page on the www.ctdssmap.com Web site.

Back to Table of Contents

Attention Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) and Personal Care Assistance (PCA) Waiver Service Providers and Home Health Agencies

Timely Resolution of Prior Authorization Issues

It is important that providers reconcile their Remittance Advices (RA) in a timely manner to identify Prior Authorization (PA) issues which must be directed to the Access/Case Management Agencies (ABI, CHC and PCA waiver clients) or the Department of Social Services Case managers for resolution. Not addressing PA issues timely can lead to a delay in PA being corrected or added to the care plan resulting in unpaid claims until the authorization issue is resolved. Providers should contact the applicable Access/Case Management agency as soon as a service authorization issue is identified as noted below:

Connecticut Community Care (CCCI) - serviceauthissues@ctcommunitycare.org

Providers must include the following information if applicable, when submitting service authorization issues to **CCCI**: provider name, client name, client ID number, CCCI number, EOB code on rejecting claim at DXC Technology, from and through dates of service, type of service (SNV, Companion, PCA etc.), frequency of service (spanned dates, monthly or weekly), number of units needed, CCCI service order number, if available, and any comments the provider wishes to communicate to CCCI.

South Western Connecticut Area on Aging (SWCAA) - SWCAABillings@swcaa.org

Agency on Aging of South Central CT (AOASCC) - chcbilling@aoascc.org

Companies without secure e-mail, please fax service order inquiries to **AOASCC** at: (203) 528-0455.

Western Connecticut Area on Aging (WCAA) - contact **WCAA** directly at (203) 465-1000.

Providers must include the applicable following information when contacting **SWCAA, AOASCC** or **WCAA:** client name, client ID number, type of service, dates of service, frequency of service and the number of units or hours per visit.

For PA issues related to Care Plans for Self-Directed Clients on the Connecticut Home Care Program, please contact:

Melva Cooper, RN

Department of Social Services (DSS)

(860) 424-5863 or melva.cooper@ct.gov

(continued on page 5)

Back to Table of Contents

(continued from page 4)

For Autism Waiver Service Authorization issues, please contact the client's Case Manager at the Department of Social Services Community Options Unit:

Alison Hummel – Case Manager (860) 424-5518 or Alison.hummel@ct.gov

Amy James – Case Manager (860) 424-5445 or amy.james@ct.gov

Mike Olesen – Case Manager (860) 424-5853 or michael.olesen@ct.gov

Michael J. Blaszko – Supv. Case Management (860) 424-5381 or Michael.Blaszko@ct.gov

Amy Dumont, LCSW – Manager (860) 424 5173 or amy.dumont@ct.gov

Failure to resolve PA issues timely can also result in your claims denying for timely filing if not resubmitted within the Department of Social Services (DSS) timely filing guidelines. Providers should reference Chapter 5, Section 5.6 for timely filing guidelines applicable to the client's benefit plan and services provided.

Back to Table of Contents

Home Health, Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) and Personal Care Assistance (PCA) Waiver Service Providers

Updated Procedure Code Crosswalks for the ABI, Autism, CHC and PCA Waiver Programs

The Procedure Code Crosswalk for each of the Waiver Programs noted has been revised to reflect the addition of a number of code lists and corresponding procedure codes required to be on the client's care plan. The Crosswalk is organized by billing provider type (Access Agency, Allied Community Resources, Waiver Service Provider, Home Health Agency and Community First Choice) and lists the procedure codes or code lists which can be authorized on the client's care plan that are billable or associated to codes that can be billable by the provider type listed. Each code listed contains a description of the service corresponding to the code authorized and, if authorized by a list code, the procedure codes and modifiers that may be billed by the provider. The Crosswalk also notes the procedure code's unit of measure, ability to span dates of service, valid frequency of service, care plan limitation, applicable funding source, Electronic Visit Verification (EVV) Mandate and the effective date of service the code could be added to the care plan.

Providers may access the Crosswalks applicable to the waiver clients they serve on the

(continued on page 6)

Back to Table of Contents

(continued from page 5)

www.ctdssmap.com Web site via the Training page. From the Home Page, select Provider, Provider Services, Provider Training and click the "here" link to access the Training Information page. Under the "Materials" heading, select the applicable Waiver Workshop link, then select the "Procedure Code Crosswalk 2018" link.

As a reminder, the Training Page also contains links to the yearly refresher Waiver Service Provider and Home Health Workshops which can be beneficial to new staff and those that were unable to attend the workshop presentations. It is strongly encouraged that providers review the yearly refreshers if they are not able to attend as these have important program information that providers should be aware of.

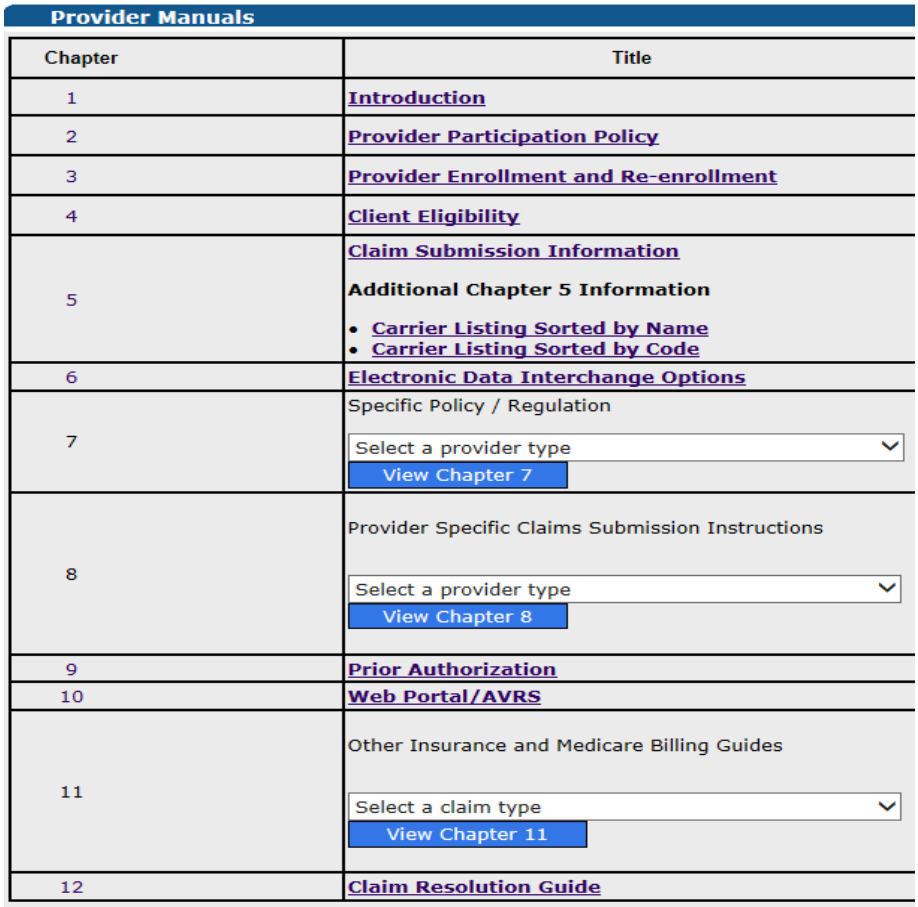
Providers may also access the Procedure Code Crosswalks in Chapter 8 of the Provider Manual on the www.ctdssmap.com Web site. From the Home, page select Information then Publications. Under the Provider Manuals Heading, Chapter 8, select your provider type from the dropdown menu, then click "View Chapter 8".

Waiver Service Providers can access a specific waiver Crosswalk by clicking the Waiver name at the table of contents to access the appropriate Waiver section. A link to the specific Waiver Procedure Code/Frequency Crosswalk can be found in the Waiver section of the chapter. Waiver Service providers will also find links to four Waiver Crosswalks (ABI, Autism, CHC and PCA) in the "Claim Submission Instructions" section, field 24D, in Chapter 8 of the Provider Manual.

Home Health Agencies will find copies of each of the Waiver Crosswalks in the "Claim Submission Instructions" section, field 44, in Chapter 8 of the Home Health Provider Manual.

Back to Table of Contents

Provider Manual Overview



Provider Manuals

Chapter	Title
1	Introduction
2	Provider Participation Policy
3	Provider Enrollment and Re-enrollment
4	Client Eligibility
5	Claim Submission Information **Additional Chapter 5 Information** • Carrier Listing Sorted by Name • Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
7	Specific Policy / Regulation Select a provider type View Chapter 7
8	Provider Specific Claims Submission Instructions Select a provider type View Chapter 8
9	Prior Authorization
10	Web Portal/AVRS
11	Other Insurance and Medicare Billing Guides Select a claim type View Chapter 11
12	Claim Resolution Guide

Providers are reminded to refer to the Provider Manual Chapters found at www.ctdssmap.com for questions pertaining to the Connecticut Medical Assistance Program (CMAP). The manuals can be found under Information > Publications > Provider Manuals. The Provider Manual is divided into twelve (12) chapters as follows:

Chapter 1- **Introduction**- Provides information on CMAP and the responsibilities of the Department of Social Services (DSS) and DXC Technology. The chapter mentions various benefit plans that are covered under CMAP, such as:

- **HUSKY A** - Family Medicaid
- **HUSKY B** - State Children's Health Insurance Program (SCHIP)
- **HUSKY Plus** - supplemental coverage of goods and services for eligible HUSKY B clients
- **HUSKY C** - Previously referred to as Medicaid, Title XIX, fee-for-service, or Adult Medicaid
- **HUSKY D** - Previously referred to as Medicaid for Low Income Adults (LIA)
- **Special Programs -** Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), Healthy Start, Waiver Programs, Medicare Covered Services, Family Planning, Tuberculosis
- Connecticut AIDS Drug Assistance Program (CADAP)

(continued on page 8)

Back to Table of Contents

(continued from page 7)

Chapter 2- **Provider Participation Policy -** Details regulations for provider enrollment in CMAP.

Chapter 3- **Provider Enrollment & Re-enrollment -** Instructions for providers regarding enrollment and re-enrollment in CMAP.

Chapter 4- **Client Eligibilty -** Contains information regarding client eligibility in CMAP, client eligibility verification and third party liability.

Chapter 5- **Claim Submission Information** - Contains general claim submission information, claim related correspondence, behavioral health program guidelines, remittance advice, electronic funds transfer, Medicare/insurance carrier information and program forms applicable to most providers participating in CMAP.

Additional Chapter 5 Information:

Carrier Listing Sorted by Name - Contains a list of monthly updated Other Insurance carriers by name alphabetically.

Carrier Listing Sorted by Code - Contains the same list of Other Insurance carriers sorted by carrier code.

Chapter 6- **Electronic Data Interchange Options -** Contains information regarding methods of electronic data interchange between the CMAP provider community and DXC Technology.

Chapter 7- **Specific Policy/Regulation -** Contains the Medical Services Policies that pertain to each specific provider type and specialty. Information is categorized by provider type.

Chapter 8- **Provider Specific Claims Submission Instructions** - Contains instructions on the claim submission process for all provider types and specialties. Information is categorized by provider type.

Chapter 9- **Prior Authorization** - Contains information on when it is appropriate to request prior authorization (PA), how to request PA and the forms necessary to do so.

Chapter 10- **Web Portal/AVRS** - The Connecticut interChange Medicaid Management Information System (MMIS) Web Portal facilitates information access and exchange between DSS and interChange stakeholders. The Web Portal is comprised of two separate applications that are referred to as the Public Web site and the Secure Web site. The Automated Voice Response System (AVRS) provides the following functionality to providers 24 hours a day, 7 days a week (except during maintenance down time):

- Security
- Self-Service
- Transferring to a Customer Service Representative

Chapter 11- **Other Insurance and Medicare Billing Guides** - Provides information on the billing guidelines for Medicare and other insurance. This chapter is categorized by the following claim types:

- Dental Other Insurance / Medicare Billing guide
- Institutional Other Insurance / Medicare Billing Guide
- Professional Other Insurance / Medicare Billing Guide

Chapter 12- **Claim Resolution Guide** - Provides a list of the most common Explanation of Benefit (EOB) codes and provides the reason the EOB sets and how to correct it. EOB codes are continually added to this chapter as new programs and policies are implemented.

Back to Table of Contents

Acquired Brain Injury (ABI), Autism, Connecticut Home Care Program for Elders (CHC), Personal Care Assistance (PCA) and Home Health Service Providers

Electronic Visit Verification at Your Fingertips

"At Your Fingertips" is a bi-monthly tip sheet to help providers navigate Electronic Visit Verification (EVV) by answering common questions and providing assistance for resolving common issues encountered by providers in their use of the EVV system. These tips have been very well received and we encourage providers to share these with their staff. Links to each tip previously published are located on the Electronic Visit Verification Implementation Important Message or by clicking here.

Attention All Providers

Social Security Number Removal Initiative (SSNRI) Update

As part of DXC Technology's ongoing effort to keep you informed of the progress of the Centers for Medicare and Medicaid Services (CMS) Social Security Number Removal Initiative (SSNRI), we would like to bring to your attention the addition of a New Medicare Card Project Frequently Asked Questions (FAQs) document on the CMS Web site. The new FAQ document is composed of questions and answers from conference calls and information sent to the CMS resource mailbox. It addresses a variety of subjects including testing, research, appeals, and provider related questions, as well as a section that addresses general program questions. The most recent version of the document can be found on the New Medicare Care Project main page at https://www.cms.gov/Medicare/New-Medicare-Card/index.html under "Where can I get more information about the new Medicare cards?".

As a reminder, CMS began mailing new cards to Medicare beneficiaries in April 2018, with a target that all Medicare cards will be replaced by April 2019. Please visit the above Web site to learn more about the SSNRI and stay up-to-date on project updates and implementations.

Back to Table of Contents

Electronic Health Records (EHR) Incentive Program Important Messages Archived

In order to streamline the information available on the Electronic Health Records (EHR) Incentive Program Web page of the www.ctdssmap.com Web site, the Department of Social Services (DSS) and DXC Technology have started archiving the Important Messages posted on the page. This will ensure that providers participating in the EHR Incentive Program have the latest and the most relevant information presented to them from the EHR Incentive Program page. However, this doesn't mean that you have lost access to the Important Messages that were posted in the past. To access archived messages from the EHR Incentive Program page, scroll to the bottom of the page and select the "Click here for Archived Messages" link. This will bring you to the "Messages Archive" page under the "Information" link. The archived messages are grouped by the year posted. The panel for each year can be expanded by clicking on the + symbol to reveal the messages posted in that year.

In addition to the EHR Important Messages, providers can access archived Remittance Advice (RA) Banner Announcements and Important Messages posted on the Home page of the www.ctdssmap.com Web site.

Back to Table of Contents

Appendix

Holiday Schedule

Date	Holiday	DXC Technology	CT Department of Social Services
7/4/2018	Independence Day	Closed	Closed
9/3/2018	Labor Day	Closed	Closed
10/8/2018	Columbus Day	Open	Closed
11/12/2018	Veterans 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.

PB18-36 July 1, 2018 Changes to the Connecticut Medicaid Preferred Drug List (PDL)

PB18-36 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)

PB18-36 Reminder About the 5 day Emergency Supply

PB18-35 Documentation Guidelines for Evaluations & Management Services Performed by Students

PB18-34 Enhanced Secure Web Site Features for Password Resets, Locked Accounts and Disabled Accounts

PB18-30 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health and CADAP Programs)

PB18-29 Expedited Medicaid Eligibility Processing For Individuals with Medical Emergencies

PB18-28 Obstetrics Pay for Performance Program

PB18-27 New Proc/Mod List Codes for Nursing Management and Evaluation of the Plan of Care under Autism, Acquired Brain Injury (ABI), Connecticut Home Care (CHC) and Personal Care Assistance (PCA) Waiver Programs

PB18-25 Compression Garments (A6549/A4465) Coverage Guidelines

PB18-23 New Genetic Testing Prior Authorization Forms

PB18-22 Access Requirements for Freestanding Behavioral Health Enhanced Care Clinics Under the CT Behavioral Health Partnership

PB18-21 Updated Cystic Fibrosis (CF) Prior Authorization Request Form for Orkambi, Kalydeco and Symdeko

PB18-20 Electronic Visit Verification (EVV) Enhancement Training—Using the Temporary Client and Attributes Enhancements

PB18-19 Web Portal Enhancement—Alternate Service Location Addresses

PB18-18 Corrected and Revised—Reductions and Adjustments to Payment for Durable Medical Equipment (DME) to Remain Compliant with Federal Law and Additional Reimbursement Reductions to Medical Equipment, Devices And Supplies (MEDS)

PB18-17 Electronic Visit Verification Enhancement—Alternate Claim Solution

PB18-16 Tisagenlecleucel (Kymriah™) and Voretigene Neparvovec-rzyl (Luxturna™) Coverage Guidelines

PB18-15 Reductions and Adjustments to Payment for Durable Medical Equipment (DME) to Remain Compliant with Federal Law and Additional Reimbursement Reductions to Medical Equipment, Devices and Supplies (MEDS)

PB18-14 Changes to Pricing Methodology for Certain Miscellaneous Custom Wheelchair Components Billed under Procedure Code K0108

PB18-13 Payment Error Rate Measurement (PERM) Program Audit Requests

PB18-12 Requesting Authorization for Non-emergency Ambulance Services for Retroactive Eligibility

PB18-11 Timely Completion of Medical Records in the Office and Outpatient Settings

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

DXC Technology
PO Box 2991
Hartford, CT 06104
www.ctdssmap.com