Connecticut Department of Social Services
Caring for Connecticut

Connecticut Medical Assistance Program
Department of Social Services & EDS
www.ctdssmap.com

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Post Go-Live "Hot Topics":

- Implementation Issue and Resolution Communication Process: Important Messages, Global Messaging and Banner Pages
- National Provider Identifier (NPI) Claim Submission Procedures
- Husky A Clients Now Traditional Medicaid Fee-for-Service
- Need a speaker for your next staff pharmacist meeting?
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Implementation Issue and Resolution Communication Process: Important Messages, Global Messaging and Banner Pages

Important Messages

In an effort to communicate timely with providers when issues arise impacting claims processing and financial cycles EDS is using the IMPORTANT MESSAGES section of the HOME page on the new interChange Web site **www.ctdssmap.com**. Notices regarding claims processing issues will be posted based on provider type, for example, All Providers, Durable Medical Equipment or Professional Billers.

The postings will provide you with the following: details of the issue, status of the issue, how this impacts the provider, action taken by EDS, and action needed by the provider. Please check this section periodically for updates on claims processing issues.

Global Messaging

In addition to Important Messages, EDS will use Global Messaging to notify Providers and Trading Partners of issues via the new secure e-mail function in the provider portal. A notification letter is sent either to the e-mail address or mail address provided in your Account Setup. Global messages can be viewed from your Account Home page or by selecting 'Global Messages' and then 'Global Messages List.'

Banner Messages

EDS will post updates to issues, action taken and issues resolved via Banner Pages of your Remittance Advice (RA). These are specific to the action taken or issues identified in a particular financial cycle. If claims have been reprocessed for an issue that has been resolved in a cycle it will be posted in a Banner Message. Banner Messages can be viewed on the portal: 1) Go to www.ctdssmap.com 2) Select 'Information' 3) Scroll down to 'RA Banner Announcement'.

National Provider Identifier (NPI) Claim Submission Procedures

EDS resolved a claims processing issue related to Explanation of Benefits (EOB) code 1945 "Claim/detail denied. Billing/performing provider could not be determined" in the April 11, 2008 claim cycle. Claims which have denied for this EOB should be corrected and resubmitted by following proper paper or electronic claim submission procedures. Common errors on the electronic 837 claim record include missing or incorrect taxonomy and nine digit zip code in Loop 2010AA. Group billing on the 837P claim transaction must provide rendering provider information in Loop 2310B. Common errors on the paper claim form include an incorrect taxonomy code for the billing or rendering provider and an incorrect nine digit zip code of the billing provider. Providers must also contact EDS and update their NPI information when a change in NPI or taxonomy occurs. A bulletin will soon be published communicating these instructions and will be posted to the home page on the www.ctdssmap.com Web site.

In this Issue

HUSKY A Clients Now Traditional Medicaid Fee-for-Service

With the termination of the HealthNet and the WellCare managed care contracts effective March 31, 2008, HUSKY A clients have been provided the option of enrolling in Community Health Network of Connecticut (CHN), Anthem's Blue Care Family Plan, or the Department's Medicaid fee-for-service program.

There are an estimated 43,000 HUSKY A clients who enrolled in the Medicaid fee-for-service program effective April 1, 2008. All HUSKY A clients will continue to receive their behavioral health services from the CT Behavioral Health Partnership (CT BHP).

Providers can obtain eligibility information from the Automated Eligibility Verification System or using the Eligibility Verification feature on the Web Portal **www.ctdssmap.com**.

Provider Electronic Solutions and 271 X12N Response transactions in the Eligibility Benefit Information Section will indicate:

- Plan Coverage Description: Medicaid Services
- Plan Coverage Description: Behavioral Health Partnership HUSKY A FFS
- Message text: HUSKY A. For Behavioral Health Services call BHP at 877-552-8247

EDS has identified a claims processing issue beginning with the April 11, 2008 claims processing cycle related to claims submitted for these HUSKY A clients who enrolled in the Medicaid fee-for-service program. Claims have denied in error for Explanation of Benefit code 4021 "The procedure billed is not a covered service under the client's benefit plan." EDS is working to resolve this issue and will communicate to the provider community the corrective action plan in a banner message once this issue is resolved.

Need a speaker for your next staff pharmacist meeting?

Want to know why Pharmacy Prior Authorization is required for some generic drugs and not others? Let us help you and your staff understand this and other policies behind pharmacy claims processing for Medicaid, ConnPACE, HUSKY, and SAGA clients. It will help your pharmacy operations run more efficiently and help limit exposure to potential audit issues. Our trained, professional pharmacy provider representative and a staff pharmacist will provide an explanation and instruction on the following top billing issues:

- Prior Authorization requirements for Medicaid, ConnPACE HUSKY, and SAGA clients.
- One time prior authorizations for non-formulary drugs with Medicare Part D.
- One time prior authorizations for non-preferred drugs and brand medically necessary exceptions for HUSKY A and Medicaid clients.
- HUSKY and SAGA clients transition to traditional fee for service program.
- Using the Preferred Drug List to optimize clients' drug therapies.
- Billing Medicare Part B medications for Medicaid and ConnPACE clients.
- Coordination of Benefits or processing Medicaid as secondary insurance with Medicare Part D and commercial insurances.
- Processing ConnPACE and Medicare Part D low income subsidy clients electronic compound claims; requirements and submission clarification codes.
- Properly responding to DUR alerts.
- Proper documentation of diagnosis code requirements.
- Proper processing for Optimal Dosing edit.
- Acceptable use of Dispense As Written (DAW) codes.
- Accessing www.ctdsmap.com or the automated voice response system (AVRS); your ID and password are crucial for staff to access information.
- Complying with the tamper resistance prescription pad requirements now and in October 2008.
- Understanding National Provider Identification (NPI) requirements.

If your staff needs assistance in any of these areas, EDS wants to be invited to your next staff meeting. Small or large groups are acceptable and we can tailor the presentation to address the issues that are most important to your staff.

Call Ellen Arce, Pharmacy Manager, at 860-255-3822 to schedule a convenient date and time.

Other Insurance Requirements/TPL

Medicaid is always the payer of last resort, so a response from each and every other insurance policy the client has must be indicated on a claim.

If a client has other insurance coverage and a payment was received, the 3-digit other insurance carrier code, paid amount, and payment date must be indicated on the claim. Other insurance denials must also be reflected on the claim form. Please refer to directions below for specific field requirements on the UB-04 and CMS-1500 forms.

The other insurance payment amount is deducted from the provider's allowed amount for the claim. If the insurance payment amount exceeds the Medicaid allowed amount, no payment will be made by Medicaid.

NEW: The other insurance Explanation of Benefits (EOB), indicating a payment or denial, does not need to be attached to the claim but must be maintained for audit purposes.

If the client has Medicare and a payment was received, enter "Medicare" in this field. Do not enter the amount Medicare paid on the claim. If a denial from Medicare was received, enter "Medicare Not Applicable" or "N/A". NOTE: If a Medicare Health Maintenance Organization (HMO) is the primary insurer, the words "Medicare HMO" must be indicated in this field (Field 9d of the CMS-1500 Claim Form; Field 50 of the UB-04 Claim Form).

The Explanation of Medicare Benefits (EOMB), indicating a payment or denial from Medicare, is always required to be attached to the paper claim.

Carrier Code list instructions:

There are two carrier code lists. One list shows carrier codes in numeric order and the other list is alphabetic by carrier name. Carrier code lists can be accessed on the Connecticut Medical Assistance Program Web site at: www.ctdssmap.com. If the three-digit code for a specific insurance carrier does not appear on the list, the provider should enter "999", along with the name of the insurance carrier in the appropriate field on the claim form.

To access the Carrier Code lists from the Connecticut Medical Assistance Program Web site Home Page go to: www.ctdssmap.com 1) Click on 'Information' 2) Click on 'Publications' 3) Scroll Down to 'Provider Manuals' 4) Select 'Carrier Listing' under Additional Chapter 5 Information.

UB-04 Forms

Field	Field Name	Comment
31-34.	OCCURANCE CODE/DATE	If insurance denied enter code 24 and the date of denial.
50.	PAYER NAME A, B, C	Indicate the three (3) digit carrier code(s) in the payer field.
54.	PRIOR PAYMENTS A, B, C	Indicate the amount in the prior payment field in the same order as the carrier code appears in the payer field (field 50).
80.	REMARKS	Enter the other insurance paid date, if applicable.

CMS-1500

Field	Field Name	Comment
9a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the client's 9-digit Connecticut Medical Assistance Program ID number when submitting a claim for Medicare coinsurance and deductible.
9d.	INSURANCE PLAN NAME OR PROGRAM NAME	Enter commercial insurance 3 digit carrier code, payment amount or, N/A if no payment is made and date of EOB/Voucher. (Note: if payment is made from commercial insurance, field 29 must reflect payment amount). For claims where Medicare has not made a payment, enter MPB n/a and Date of EOMB or CMS letter.

If you have questions, please contact the Provider Assistance Center (PAC) at 1-800-842-8440 (in-state toll free) or (860) 269-2028 (local to Farmington, CT)**.**

Third Party Liability (TPL)

Client eligibility verification includes the identification of any third party liability or private insurance. Providers must pursue each and every known client third party liability. Reference TPL bulletin PB08-23 for more information.

When a provider identifies a discrepancy between the Department's third party liability information (that is as found on AEVS) and the client's actual coverage, it is essential that the provider notify the Department of Social Services of these changes in order to avoid having claims unnecessarily denied.

In this situation, the provider may use the TPL Information Form. The Department's third party liability contractor, Health Management Systems, Inc. (HMS), receives these forms.

- HMS verifies the reported client third party information and transmits to the Department the necessary additions, corrections or deletions that will be made to the client's third party liability record.
- HMS contacts the provider directly in writing with its results within forty-five (45) days of receipt of the TPL Information Form so that the provider knows that the client's third party liability information has been corrected and updated.

Concurrently, the provider may review the AEVS to confirm the change to a client's third party liability information.

Providers may contact HMS toll free at 866-277-4271 or via e-mail at **ctinsurance@hmsy.com** to obtain the TPL Information Form.

Pharmacy Third Party Liability (TPL) Issue

Pharmacy providers are requested to contact the Department of Social Services when they believe inaccurate or outdated TPL information exists for a Medicaid fee-for-service, HUSKY A or SAGA client. We ask that the pharmacy call and notify the Department of Social Services **Third Party Liability Unit at 860-424-5975** and provide: client's name, client identification number, the health insurance company, a description of the specific problem, pharmacy telephone number and pharmacy contact information. This information can also be **faxed to Third Party Liability Unit at 860-424-5333**. The Department will make every attempt to verify and update the TPL information the same day, and will update the system no later than the next business day.

Mass Adjustments

Rate mass adjustments in the new Connecticut interChange system are scheduled to begin in May 2008. Mass adjustments will now be done more frequently than twice a year. Mass adjustments may be processed due to an update for retroactive rates, patient liability, or retroactive date of death changes. Rate mass adjustments will be done first and will appear on your remittance advice (RA) with an internal control number (ICN) beginning with region 53 or 55 with one of the following explanation of benefits codes (EOB): 8186 "Claim Was Adjusted Due To A Provider Rate Change", 8242 "Claim Was Adjusted Due To A RCC Level III Rate Change", 8243 "Claim Was Adjusted Due To A UCC Annual Level III Rate Change", or 8244 "Claim Was Adjusted Due To A UCC Level III Rate Change". The first rate mass adjustment will be run on May 16th.

Reading and Understanding the PDF Version of your Remittance Advice
www.ctdssmap.com

The PDF version of the RA has under gone significant changes as a result of the Connecticut interChange MMIS implementation. Changes in the new interchange RA include:

1. Address Page
In addition to traditional address information, the address page will be enhanced to include the provider's primary taxonomy code and Automated Voice Response System (AVRS) ID.

2. Banner Messages
Banner messages will increase in size to accommodate more detailed messages which may include claim processing issues that have been identified and their resolution in regards to current or future claims processing.

3. Claim Activity/Status
- Claim activity since the last claim cycle are first sorted by Claim Type (Medicare, CMS-1500, Dental, Pharmacy, UB-04)
- Claims are next sorted by Claim Status with headings in order of:
  - Paid
  - Denied
  - In Process (will appear on each RA)
  - Adjustments (will include the net difference between the original claim and the adjustment claim).

The new RA will allow reporting of up to 20 header level and 20 detail level Explanation of Benefit (EOB) codes for each claim. EOB codes have increased from three to four characters, a description of those found at the claim header or detail can be found on the last page of your RA. Paid details may reflect EOB codes applicable to the processing of benefit plans under which the client may be covered with no impact to payment of services billed.

4. Financial Transactions
Financial activity will be reported for both payouts and non-claim specific refunds received and applied during the current claim cycle. The RA will include all outstanding accounts receivables (A/R) in A/R number order.

5. Summary Report
The summary report continues to provide current, month-to-date and year-to–date totals for all claim and financial transaction activity. The summary report will also include the total dollar amount of all claim-specific Account Receivables established in previous cycles which have not been satisfied.

6. EOB Descriptions
A list of EOB codes used in the preceding RA pages and their corresponding descriptions are reported and will accommodate the increased number of EOBs posted to each claim. EOB code values and descriptions differ from those reported on the legacy PDF RAs. A complete list of EOB codes and their values can be found at **www.ctdssmap.com**, click on Information, Publications, Claims Processing Information, Explanation of Benefits (EOB) list.

For those providers who also receive an ASC X12N 835 Payment/Advice, a crosswalk of EOB codes to the HIPAA adjustment reason codes can be found at **www.ctdssmap.com**, click on information, publications, scroll down to claims processing information. Click on Medical Assistance Program EOB Crosswalk.

The most current 10 RAs in the PDF version will continue to be available via the Web. The PDF RA will be located on the Provider Secure Web Portal.

The last four (4) months of pre-interChange PDF RAs will remain available for download until May 30, 2008. Providers are encouraged to download and save any files they may require in the future as they will no longer be available.

A find feature is available for RA files saved electronically. The find feature may be useful in finding a specific claim by ICN or claims by client ID or name or account number.

Quarterly News

Quarterly Claim and Code News

Adjustment Reason Codes

Providers are reminded to periodically compare the adjustment reason codes they are using with those listed on the Washington Publishing Web site to ensure they are using only valid codes. End dated adjustment reason codes will cause claim denials in interChange. Codes that are end dated are noted by a stop date under the Adjustment Reason Code description.

Additionally, providers need to make sure codes do not have leading zeros. Claims will deny for Edit 2516 "Claim adjustment reason code invalid" when a valid adjustment reason code of "2" is entered in as "002".

The Washington Publishing Company Web site can be accessed from **www.ctdssmap.com.** 1) From the home page click 'Information' 2) Click 'Links' 3) Scroll to 'HIPAA Information 4) Click on the 'Washington Publishing Company' link.

Resubmit Medicaid Hearing Aid Code Claims

Audiological claims that were impacted by either of these denials, 'Bill Medicare First' and 'No Reimbursement Rule for Provider Type/ Specialty', can be resubmitted. An updated rule went into effect the end of March. As a result, the following Medicaid only hearing aid procedure codes V5010, V5014, V5050, V5060, V5130, V5140, V5160, V5200, V5240, V5241, V5260, V5264, V5266 can now be billed directly to Medicaid. Providers should not submit Medicare and/or other insurance information in Field '9d' on the CMS 1500 claim form for these Medicaid only procedure codes. Previously denied claims will be reprocessed at a later date and communicated to the provider community. Providers may choose to resubmit their claims themselves and not wait for the systematic reprocessing.

Quarterly Internet Tip

About Passwords

Secure access to the Internet Web site depends on the use of passwords. Every 60 days, you are prompted to change your password. Please choose passwords that can easily be remembered.

You must enter the existing password, the new password, and then you are asked to confirm this new password. Passwords are case sensitive. If entries in the new passwords do not match, you receive a "Your password was not confirmed" error message.

If a Web user does not use their ID and password for 60 days, their user account is disabled. The user has to call the Provider Assistance Center (PAC) at 1-800-842-8440 (in-state toll free) or (860) 269-2028 (local to Farmington, CT) to reset their user account.

Quarterly News

Quarterly Fee Schedule Highlight

Dental Fee Rates

A revised Medicaid Dental Services Fee Schedule was posted to the web with an effective date of April 1, 2008. To view or download a copy of the fee schedule: 1) Go to **www.ctdssmap.com** 2) Select 'Provider' 3) Click on 'Provider Fee Schedule Download' 4) Scroll down to 'Dental' 5) Select '04/01/2008'.

General highlights

- All rates have increased.
- The posted dental fee schedule is reflective of the new pediatric dental rate of reimbursement for all codes.
- The NEW rate of reimbursement for the adult fee schedule is 52% of the pediatric fee schedule.

Specific code changes

The Department of Social Services is incorporating the 2008 Current Dental Terminology (CDT) changes in its Dental Fee Schedule effective April 1, 2008. Procedure codes that have been added or deleted are identified in Bulletin PB 2008 -19.

Other Recently Updated Fee Schedules:

	Effective Date	Policy Transmittal
Chiropractor	1/1/2008	PB08-01
MEDS-Hearing Aid	2/1/2008	PB08-02
Natureopath	1/1/2008	PB08-04
Physician	1/1/2008	PB07-83
Medical Transportation	7/1/2007	PB08-27
Vision Care	1/1/2008	PB08-25

Upcoming Fee Schedules:

Dialysis Clinic
Medical Clinic
Community Clinic
Family Planning

All fee schedule updates will be announced via a Policy Transmittal to the impacted providers.

To view or download a copy of a fee schedule: 1) Go to www.ctdssmap.com 2) Select 'Provider' 3) Click on 'Provider Fee Schedule Download'

EDS Logo
EDS Address

Provider Address

EDS Contact Information for PAC and CAC

The Provider Assistance Center (PAC) has grown in size and features highly trained representatives to assist with your calls.

Hold times have been reduced as additional staff have been added, however we still are experiencing peak call volumes throughout the day. To minimize call hold times we are encouraging providers to contact us during the low call volume periods of 8 am to 9 am or 4:30 pm to 6 pm (EST). Our extended hours of 8 a.m. to 6 p.m. (EST), continue through May 31, 2008.

The Client Assistance Center (CAC) has multi-lingual representatives available to assist callers.

Automated Voice Response System Features are available 24/7 for both centers, excluding scheduled maintenance down times.

EDS Provider Assistance Center (PAC):

The EDS Provider Assistance Center is available to Connecticut Medical Assistance Program providers Monday through Friday, 8 a.m. to 5 p.m.* (EST), excluding holidays at:

- 1-800-842-8440 (in-state toll free)
- (860) 269-2028 (local to Farmington, CT) NEW
- (860) 269-2033 (Fax) NEW

*Extended hours 8 a.m. to 6 p.m. (EST) through May 31, 2008.

EDS Holiday Schedule

Memorial Day	May 26, 2008
Independence Day	July 4, 2008

EDS Client Assistance Center (CAC):

The EDS Client Assistance Center is available to Connecticut Medical Assistance Program clients Monday through Friday, from 8 a.m. to 5 p.m. (EST), excluding holidays at:

- 1-866-409-8430 (toll free)
- (860) 269-2031 (local to Farmington, CT)
- (860) 269-2027 (Fax)