The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

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Attention: Dental Providers

Annual Dental Benefit Maximum Reminder

Dental providers participating in the Connecticut Medical Assistance Program (CMAP) are reminded about the annual dental benefit maximum of $1,000 for dental services provided to adult clients ages 21 and older enrolled in HUSKY A, C and D benefit plans. The dental benefit limit resets on January 1st of each year.

Providers can find the amount of the annual maximum and the remaining balance for the calendar year in the client eligibility response from either the secure Web portal or the batch eligibility HIPAA 270-271 Eligibility Transaction. The balance amount returned in the eligibility transaction reflects the claims processed for the client at the time eligibility is verified.

Providers may also utilize the "Claims history for specific services" lookup from the secure Web portal www.ctdssmap.com to find the remaining amount of the annual dental benefit. Once logged into their secure Web portal, click on "claim history for specific services" from under the "Claims" link. Enter the Client ID, select "Dental Benefit Limit" as the Inquiry Type, enter the Date of Service and click "Search".

Providers are strongly encouraged to submit unpaid claims for processing and payment on a timely basis when procedures are completed and delivered. All claims for clients are processed and are paid based on their submission date; on a first submitted first paid basis.

It is crucial to inform the client ahead of providing any services of their remaining balance and whether they will be responsible for paying for the service(s) out of pocket. Once a client has reached their annual dental benefit limit and a claim is submitted for dental services for the client, the detail(s) on the claim will post Explanation of Benefit (EOB) code 6250 – Dental Annual Benefit Limit Exceeded. For any detail that posts EOB 6250, the Remittance Advice (RA) will list the amount for which the client is responsible.

If the provider feels that the services beyond the annual dental benefit limit are medically necessary, they must seek prior authorization (PA) before providing services. Providers can request PA from Benecare Dental Plans on behalf of the Connecticut Dental Health Partnership (CTDHP) electronically via the www.ctdhp.com provider portal. Supporting documentation detailing the medical necessity will be required in such instances. If the PA is approved then the provider can provide the services to the client and be paid by CMAP beyond the annual dental benefit maximum.

Attention: All Providers

How to Request a Change to the Master User for Your Secure Web Portal Account

There may be instances where the individual who had set up the secure Web portal account for a provider or trading partner on the www.ctdssmap.com Web site may leave the organization. How would a provider go about requesting a change to the master user for their secure Web portal account? Providers will be required to submit a Master User Change Request with the following information:

- The Master User Change Request must be on office letterhead.

- The letter must clearly state the reason for the Master User Change Request.

- The letter must contain the previous user name and state 'is no longer the master user for XXX reason'.

- The letter must list the new user's FULL name.

- The letter must list the provider's log in User ID, AVRS ID (Medicaid Provider Number) or NPI.

- The letter must list the new master user's email address, telephone, and fax number.

- The letter must be signed and dated by either an owner, board member or authorized representative that was listed on the last enrollment application.

- The date of the letter must be within 30 days of submission to DXC Technology.

The Master User Change Request should be faxed to 1-877-413-4241. DXC Technology will contact the new master user within 48 hours of receiving the letter with a reset password. Please be aware that the User ID for the secure Web portal account remains the same as before, only the password is reset. Once the new master user has been granted access to the secure Web portal account, they should log in to the account, click on "Account Maintenance" and update the contact name, phone number, email address and security questions and answers with their own information. DXC Technology cannot update this information, only the master user can do so. Once the information has been updated by the new master user, it will be reflected in our system. The new master user will now be responsible for maintaining the secure Web portal account and all the clerks associated with the account.

Attention: Ambulance Providers

Vehicle Registration Information VIN Requirements

Effective March 1, 2019, the Department of Social Services (DSS) requires all in-state ambulance providers to have vehicle registration information on file. In-state ambulance providers will be required to have a valid Vehicle Identification Number (VIN) on all registered vehicles and will need to provide that information to DXC Technology. Failure to provide the ambulance's current VIN(s) will cause the ambulance provider to be dis-enrolled from CMAP and claims will be denied after the dis-enrollment date. The ambulance provider will then be required to re-enroll with Medicaid. In the future, DSS will be validating registrations directly with the Connecticut Department of Motor Vehicles (DMV). All ambulance providers need to make sure their vehicles' registrations remain current with the DMV.

Ambulance providers can provide their VIN(s) for their fleet of ambulances by using the "Maintain Vehicle Information" panel by going to the CMAP Web secure site www.ctdssmap.com. The Maintain Vehicle Information panel allows in-state ambulance transportation providers to view, add, update or delete the VIN(s) and the associated vehicle registration expiration date(s) for each ambulance in their fleet. To access the Maintain Vehicle Information panel, log in to the secure Web portal account and click on Demographic Maintenance. Under the Demographic Maintenance panel, select Maintain Vehicle Information. To enter the VIN, click "Add", enter the VIN and the Vehicle Registration Expiration Date and then click "Save." To enter additional VIN(s), click "Add" after each entry has been saved and repeat the process.

Attention: EVV Service Providers

EVV Refresher Training Opportunities

DSS offers a variety of *free* training resources for Electronic Visit Verification (EVV) service providers that can be used to successfully navigate Connecticut Medical Assistance Program (CMAP) and the EVV program. The following is a brief overview of the many training opportunities found on the CMAP Web site.

The New Provider Workshop - provides a basic understanding of CMAP. This free, in-person training is offered four (4) times per year and is designed to address questions and concerns that new office staff and newly enrolled service providers may have regarding their use of the www.ctdssmap.com Web site. Among the topics covered at each training workshop are client eligi-bility, claims processing, web claim inquiry and resources that can be found on the CMAP Web site.

Refresher Workshops - updates providers on new information specific to their programs and/or provider type. Among the topics covered at each training workshop are new program rules, added service codes, proc/mod lists and their uses, how to verify client eligibility, perform web claim inquiries and resources that can assist in successful claims submittal. These workshops can be used to train new staff and as a refresher for current staff in using the www.ctdssmap.com Web site and secure site features.

Important Messages - urgent messages that require immediate communication to the provider community as well as links to important information regarding recent/upcoming system changes.

Provider Bulletins - publications posted to relevant provider types/ specialties documenting changes or updates to CMAP. The online database of bulletins goes back to the year 2000 so that providers can research historical changes for their provider type.

Provider Newsletters - quarterly publications that cover a wide range of topics. The most recent provider newsletter had articles about the Alternate Claim Solution, how to resolve Prior Authorization Issues timely, and updates regarding the Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC), and Personal Care Assistant (PCA) Waiver program Procedure Code Cross-walks.

Provider Training Web page - contains links to the ABI, Autism, CHC and PCA Waiver crosswalks and the most recent yearly refresher workshops. These documents are beneficial to new staff and as a refresher for existing staff to review programmatic updates to their provider type.

Electronic Visit Verification Implementation Important Message - home of all EVV related information. This important message contains the At Your Fingertips tip sheets, all EVV training documents and videos, the service code list identifying EVV mandated and optional services, Frequently Asked Questions and the link to the Fixed Visit Verification (FVV) device request form. This document is updated frequently and should be reviewed often to ensure that providers have the most up-to-date EVV information.

Provider Manuals - offer specific information regarding CMAP and can be used to answer most questions regarding the program. Chapters 1-6 and 9-12 contain program information applicable to all provider types while Chapters 7 and 8 are provider type specific. Each chapter should be used in conjunction with any provider bulletins and Important Messages.

Attention: All Providers
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The Provider Matrix
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Are you a provider who is enrolling, re-enrolling or submitting an application to add an alternate service location address in the coming months? Are you wondering what documents you'll need to mail in order to complete your enrollment/re-enrollment/add alternate service location address application? Utilizing the Provider Matrix page can be the best place to start.

Navigate to the CMAP Web site, www.ctdssmap.com, select "Provider" from the tool bar at the top of the page then "Provider Matrix" in the toolbar to open the page shown below:
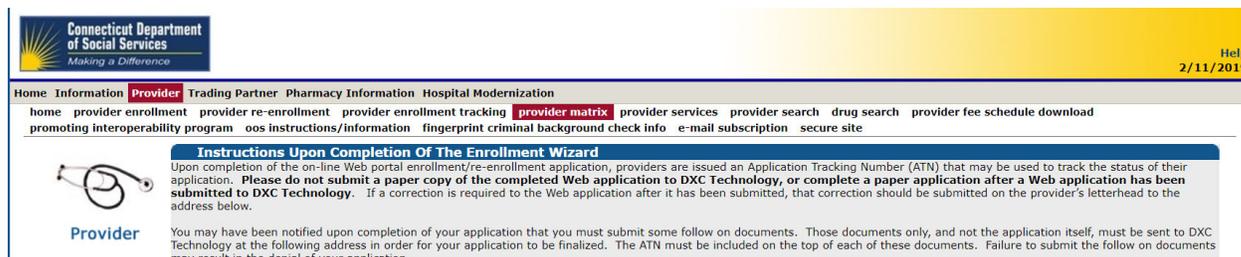
From this page, you can review the list of follow on documents you'll need for your type and specialty to complete your enrollment/re-enrollment/add alternate service location address application by clicking on the hyperlink.

To review the list of follow on documents that are required for your provider type/specialty, click on the link below and locate your type/specialty.

Follow on Document Requirement by Provider Type and Specialty

On this page, you are also able to review the next steps for your enrollment/re-enrollment/add alternate service location address application once it has been submitted.

Next Steps

Upon completion of an application and receipt of any necessary follow on documentation, DXC Technology performs a final validation of the submitted information. If any information is missing, invalid, or DXC Technology is unable to process the application, the provider will be notified via letter of the correction or additional information required. Providers will not be able to correct or modify completed applications using the Wizard but will need to submit paper corrections.

Once all information has been provided and is correct, DXC Technology will submit the completed application to the Department of Social Services Quality Assurance Unit for approval. The Department of Social Services returns an approval or denial to DXC Technology, who then notifies the provider of the final status of the application.

Attention: DDS Specialized Service Providers

Important Program Changes and Training Resource Reminders For Services Provided to Clients in Nursing Facilities

Provider Enrollment - Effective for dates of service February 1, 2019 and forward, providers must be enrolled as a DDS Specialized Services billing provider to be reimbursed by the Department of Social Services (DSS) for services provided to DDS clients residing in a nursing facility. To enroll, go to the www.ctdssmap.com Web site. From the home page, select Provider > Provider Enrollment and complete the application process.

Once enrolled, DDS Specialized Services providers will receive two separate enrollment confirmation documents in order to set-up a secure Web portal account from the www.ctdssmap.com Home Page via Provider > Secure Site. A secure Web portal account allows providers to access:

Eligibility Verification - Clients receiving DDS Specialized Services while in a nursing facility must have an active HUSKY C or HUSKY D benefit plan and be 21 years of age or older to receive these services.

Service Authorization - Prior Authorization from DDS is required for all DDS Specialized Services in order for the provider to be reimbursed by DSS.

Claim Submission - Providers must submit claims directly to DXC Technology in order to be reimbursed for the services they provide.

To learn more about the Provider Enrollment process, capabilities available via a secure Web portal account and other program resources, providers are encouraged to logon to the www.ctdssmap.com Web site. From the Home page, select the "Provider Training" link. Under the "Materials" heading, click on the "DDS Specialized Services Provider Workshops" link. Select the Enrollment or Billing Workshop "Presentation" link as applicable to the information you require.

Provider Training ⇨ Materials > DDS Specialized Services ⇨ Enrollment or Billing Presentation
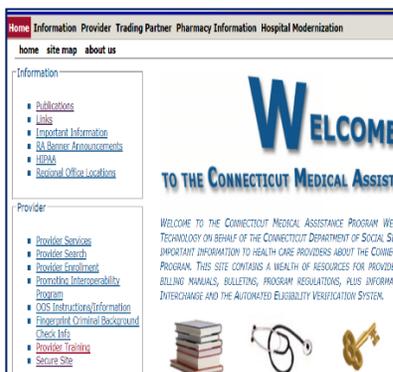
Attention: EVV Service Providers

Autism in Electronic Visit Verification

Effective February 1, 2019, the Autism waiver was implemented in the Electronic Visit Verification (EVV) program, with a mandated use date of March 3, 2019 for the following service codes:

- 1302Z - Job Coach Agency per 15 minutes
- 1304Z - Life Skills Coach Agency per 15 minutes
- 1396Z - Community Mentor Agency per 15 minutes
- 1404Z - Respite Agency in Home Individual, per 15 minutes

Please note, service code H2019 - Therapeutic Behavioral services, per 15 minutes is not mandated to be serviced via EVV, but providers are encouraged to do so for the many benefits EVV provides.

Connecticut Home Care Program (CHC), Personal Care Assistance (PCA) and Acquired Brain Injury (ABI) service providers currently using the Santrax system will see their Autism waiver clients and their Prior Authorizations (PA) in the Santrax system as of February 1, 2019. As a result, CHC, PCA and ABI service providers can use EVV to service their Autism waiver clients.

Autism service providers who are *not* currently using Santrax to capture visit data must complete the mandatory training in order to receive their Welcome Kit and gain access to their Santrax system. The mandatory training can be accessed by registering and completing the training modules in the Learning Management System (LMS). To access LMS, please navigate to https://www.sandatalearn.com?KeyName=Autismtraining.

For more information regarding the implementation of the Autism waiver in EVV, please see provider bulletin PB 18-80 Autism Waiver Program and Electronic Visit Verification (EVV). If you have questions regarding the implementation of Autism in the EVV program, please feel free to email the EVV mailbox: CTEVV@dxc.com.

Attention: Behavioral Health Clinicians

Web Claim Submissions

To submit a professional claim using the www.ctdssmap.com secure Web site, click on "Claims" then "Professional" on the main menu. The "Instructions for submitting Professional claims" document can be referenced when submitting a claim. All required fields are marked with an asterisk when submitting a claim through the secure Web site.

- Diagnosis code field – A valid ICD-10 diagnosis code must be entered.

- Procedure code field – A procedure code is required. The provider should refer to the provider's fee schedule for a list of HCPCS/CPT codes that the provider can perform and be reimbursed for. To view the provider's fee schedule, from the Web site www.ctdssmap.com go to "Provider", then to "Provider Fee Schedule Download", then scroll down and click on "I Accept", then depending on your specialty scroll down to Psychologist, Behavioral Health Clinicians or Autism Spectrum Disorder and click on the CSV link.

- Modifier field – This is not required field, but the following providers need to add a modifier: if the billing provider's specialty is Licensed Clinical Social Worker (LCSW), enter modifier AJ; if the billing provider's specialty is Licensed Marital and Family Therapists (LFMT), Licensed Professional Counselors (LPC) or Licensed Alcohol and Drug Counselors (LADC), enter modifier HO. The modifier might be required in other situations and the provider should refer to their provider bulletins and/or provider manual Chapter 8 "Behavioral Health Clinicians" for modifier requirements.

- Rendering Physician field – This is a required field when the billing provider is a behavioral health clinician group. The provider would need to enter the NPI of the individual provider who actually performed the service.

For additional training information, please refer to the behavioral health clinician workshop. Please go to the provider training page on the www.ctdssmap.com Web site. From the Home page select the "Provider Training" link. Under Materials, click on the "Behavioral Health Clinicians Workshops" link, then select the Behavioral Health Refresher Workshop 2018 link.

Attention: Primary Care Providers

Understanding Your Professional Enhanced Rate Reimbursement

One of the questions we hear frequently from 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 Increased Payments Policy and the Person Centered Medical Home (PCMH) program. Since providers can be eligible for both enhanced payment programs, the following guide to calculate the enhanced payment will help providers understand the reimbursement amounts that appear on the Remittance Advice.

<u>HUSKY Health Primary Care Increased Payments</u>

To find the Primary Care Increased Payments 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.

<u>PCMH</u>

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. To calculate the appropriate reimbursement, the provider must know the recognition level of the billing practice on the date of service (DOS) 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 Outpt Services" fee schedule.) The resulting amount is then added to the CT Medicaid fee-for-service rate or the Primary Care Increased Payment Policy Rate, if appropriate.

<u>Relevant Explanation of Benefit (EOB) Codes</u>

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

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 March 2019. 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 $88.53 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

$75.23 (Non-Facility HUSKY Health Primary Care Rate 12/01/17 - 12/31/2299)

$55.41 (Non-Facility Pediatric Physician Rate)

24% (PCMH add-on)

FINAL REIMBURSEMENT CALCULATION: ($55.41 x 24%)+$75.23 = $88.53

Appendix

Holiday Schedule

Date	Holiday	DXC Technology	CT Department of Social Services
4/19/2019	Good Friday	Closed	Closed
5/27/2019	Memorial Day	Closed	Closed
7/4/2019	Independence Day	Closed	Closed
9/2/2019	Labor Day	Closed	Closed
10/14/2019	Columbus Day	Open	Closed
11/11/2019	Veterans Day, observed	Open	Closed

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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.

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

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