May 18, 2020

Behavioral Health Clinicians Refresher Workshop

Presented by

The Department of Social Services

& DXC Technology

Presenter Paul Tom

DXC.technology

Training Topics

- Telemedicine and Audio-Only (Telephonic) Services
- Regulations / Policies
- Provider Fee Schedule
- Prior Authorization Inquiry
- Web Claim Submission
- Performing Provider Requirements
- Web Claim Adjustment
- Web Claim Submission – Third Party Liability (TPL)
- Web Claim Submission – Medicare
- Frequent Claim Denials
- National Correct Coding Initiative (NCCI)
- Training Session Wrap Up
- Questions

Telemedicine Services

- Effective for dates of service March 13, 2020 and forward, the Department of Social Services (DSS) will implement full coverage of specified synchronized telemedicine, which is defined as an audio and video telecommunication system with real-time communication between the patient and practitioner.

- Telemedicine services are covered under the Connecticut Medical Assistance Program (CMAP) only when they:
  - Are medically necessary, in accordance with the statutory definition of medical necessity in section 17b-259b of the Connecticut General Statutes.
  - Are rendered via a HIPAA-compliant, real time audio and video communication system (but note that certain popular video chatting software programs are not HIPAA-compliant).
  - Comply with all CMAP requirements that would otherwise apply to the same service performed face-to-face (in-person), including, but not limited to, enrollment, scope of practice, licensure, documentation, and other applicable requirements.
  - Services are on the behavioral health provider's fee schedule.
- All telemedicine services are in effect until DSS has notified providers in writing that the state has deemed COVID-19 no longer to be a public health emergency or DSS otherwise determines in writing that some or all of these specific measures are no longer needed to help protect the public health.

Telemedicine Services

BILLING AND DOCUMENTATION GUIDELINES

- Reimbursement/payment rates are the same as for equivalent in-person services and based on the provider's fee schedule.

- Documentation must be maintained by both the originating site provider and the distant site provider to substantiate the services provided. Originating site documentation must indicate the member received or has been referred for telehealth services.

- If a telehealth service cannot be provided or completed for any reason, such as due to technical difficulty, providers shall not submit a claim.

- Providers should use POS 02 which will indicate that the service was rendered via telemedicine
- The following modifier(s) must be billed on services that were rendered via telemedicine.
  - Modifier "GT" is used when the member's originating site is located in a healthcare facility or office.
  - Modifier "95" is used when the member is located in the home.
  - Behavioral Health Clinicians are reminded they must continue to use their applicable billing modifiers on their claims (AJ or HO).

Telemedicine Services

Group Therapy General Guidelines.

- Group psychotherapy can only be billed for members who have completed a psychiatric diagnostic evaluation, admitted to treatment and determined to need the applicable group psychotherapy level of care, as documented in the plan of care.
- Comply with all CMAP requirements that would otherwise apply to the same service performed face-to-face, provider must obtain verbal consent to treat in a group psychotherapy setting using telemedicine from each member and document such consent in the medical record and must conduct group psychotherapy using telemedicine in a private setting and advise members receiving group psychotherapy about privacy precautions.

Autism Spectrum Disorder (ASD) Direct Observation and Direction.

- Licensed Behavior Analysts (also known as Board Certified Behavior Analysts (BCBAs)) and other licensed practitioners who are already authorized to provide ASD services under Medicaid may perform the Direct Observation and Direction services via telemedicine when a technician is delivering treatment services in the home of a member.
- Direct Observation and Direction may also be billed when all three individuals (member, technician and BCBA or licensed practitioner) are simultaneously using the same telemedicine platform to deliver the ASD treatment service and observe the technician providing the ASD treatment services.

Telephonic (Audio-Only) Services

- In response to concerns over the spread of COVID-19, effective March 18, 2020 and until May 11, 2020.

- A member does not need the diagnosis or symptoms of COVID-19 to access these services via the telephone. To the extent applicable, providers must comply with applicable state laws regarding telehealth and scope of practice.

- The following CPT codes should be used to bill for behavioral health services rendered to established patients via the telephone.

Description	Billable CPT/HCPC Code	Rate
Telephone assessment and management service, 11-20 minutes of medical discussion.	98967	BH Clinician - $43.06 Psychologist - $52.28
Telephone assessment and management service, 21-30 minutes of medical discussion.	98968	BH Clinician - $46.56 Psychologist - $56.53

- CPT codes 98967 and 98968 may be billed together on the same date of service for the same member by the same provider, but only if the duration of the telephone call exceeds 41 minutes.

Telephonic (Audio-Only) Services

- All coverable behavioral health services that can be performed as telemedicine may be done via telephone (audio only) for established patients only under this policy using the CPT codes listed above to indicate that the service was done via the telephone.

- For example, if you are performing telephonic services for Psytx pt &/family for 30 minutes, you would bill procedure code 98968 with one (1) unit of service, place of service would be 02 and if you are an independent licensed behavioral clinician you would need to bill with the applicable modifier (AJ or HO).

- For telephonic services, providers do not need to include modifier 95 or GT to identify where the member was located.

- These services may only be billed by the following categories of CMAP enrolled providers.
  - Independent licensed behavioral health clinicians (licensed psychologists, licensed clinical social workers (LCSWs))
  - Licensed marital and family therapists (LMFTs)
  - Licensed professional counselors (LPCs).
  - Licensed alcohol and drug counselors (LADCs)

Telephonic (Audio-Only) Services

- Providers must adhere to the following guidelines when billing telephonic services only.

- For services that is otherwise covered for telemedicine and currently reimbursable under the provider's fee schedule can be billed for services delivered by audio-only telephone.

- Providers must obtain verbal informed consent from the member before providing services via the telephone and document such consent in the medical record. The provider must ensure each member is aware they can opt-out or refuse services at any time.
  - If the member is a minor child, a parent or legal guardian must provide verbal informed consent before providing services via the telephone.
  - Providers must develop and implement procedures to verify provider and patient identity.
  - Providers must document completely for the service billed, including a notation that the service was rendered via the telephone and follow current documentation requirements for the type of service being billed.
  - If a service cannot be provided or completed for any reason, such as due to technical difficulty, providers shall not submit a claim.

Regulations / Policies

Provider Bulletins

- Provider bulletins are available to specific provider types documenting changes and/or updates to CMAP.

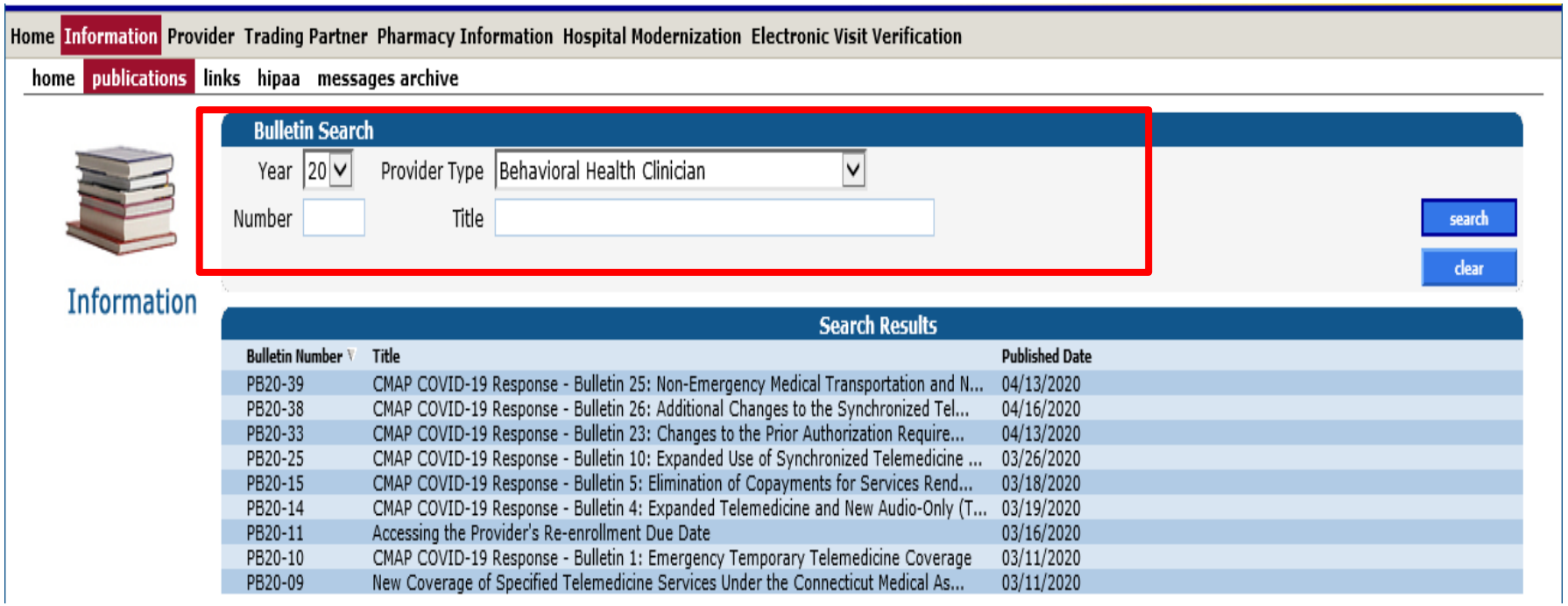
- Provider bulletins are available on the www.ctdssmap.com Web site from the Publications page.

- Providers can access the Publications page by selecting Publications from either the Information box on the left hand side of the Home page or from the Information drop-down menu.

Regulations / Policies

Provider Bulletins

- Provider bulletin search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000.



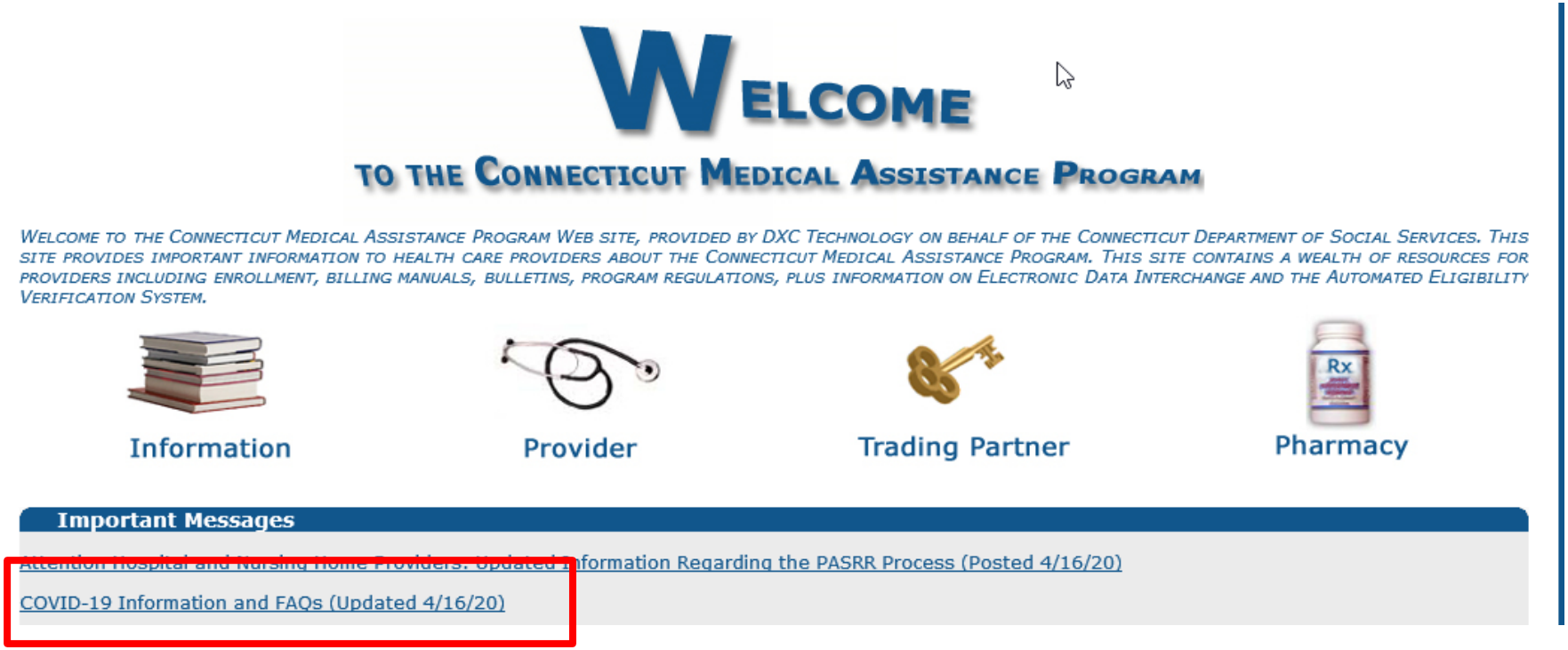
Regulations / Policies

Provider Bulletins

- Telemedicine and audio-only services and COVID-19 provider bulletins.
  - Provider Bulletin 2020-09 “New Coverage of Specified Telemedicine Services Under the Connecticut Medical Assistance Program (CMAP)”
  - Provider Bulletin 2020-14 “CMAP COVID-19 Response – Bulletin 4: Expanded Telemedicine and New Audio-Only (Telephonic) Service”
  - Provider Bulletin 2020-15 “CMAP COVID-19 Response – Bulletin 5 - Elimination of Copayments for Services Rendered to HUSKY B Members”
  - Provider Bulletin 2020-25 “CMAP COVID-19 Response – Bulletin 10: Expanded Use of Synchronized Telemedicine for Specified Behavioral Health Group Therapy Services and Autism Spectrum Disorder Services”
  - Provider Bulletin 2020-26 “CMAP COVID-19 Response – Bulletin 26 – Additional Changes to the Synchronized Telemedicine Program.”
    - Refer to Table A for a list of services.

Regulations / Policies

- Frequently Asked Questions (FAQs) document about CMAP's Response to COVID-19 (Coronavirus) is located on the www.ctdssmap.com Web page on the welcome page under Important Messages.



Regulations / Policies

Provider Manuals

The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission. The provider manual contains detailed instructions regarding CMAP, and should be your first source of information pertaining to policy and procedural questions.

- The Provider Manual is divided into twelve (12) chapters.
  - Click on the chapter title to open the document (disable pop-up blockers).
  - Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click View Chapter to access the chapter.

The provider manual is available on the www.ctdssmap.com Web site from the Publications page.

Regulations / Policies

Provider Manuals

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 Behavioral Health Clinician Services View Chapter 7
8	Provider Specific Claims Submission Instructions Behavioral Health Clinician Services 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

Regulations / Policies

- Chapter 1 – Introduction
  - Provides an overview on the CT Medical Assistance Program, the Department of Social Services' and DXC Technology's responsibilities and resources.

- Chapter 2 – Provider Participation Regulations
  - Details the CMAP regulations for provider participation.

Examples:

- Accept as payment in full either the Department's payment or a combination of Department, third party payment, and any authorized client copayment which is no more than the Department's schedule of payment, except with regard to the Department's obligations for payment of Medicare coinsurance and deductibles.

- The Department shall not pay for cancelled office visits and appointments not kept.

- A provider shall only charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services which are not coverable under the Medical Assistance Program, when the client knowingly elects to receive the goods or services and enters into an agreement in writing or such goods or services prior to receiving them.

Regulations / Policies

- Chapter 5 - Claim Submission Information
  - Chapter 5 contains the general claim submission information, claim related correspondence, behavioral health program guidelines, Remittance Advice (RA), electronic funds transfer, Medicare/insurance carrier information and program forms applicable to most providers participating in the Connecticut Medical Assistance Program.
  - Timely filing guidelines are one (1) year from the actual date of service.
    - Exceptions are listed in the section titled exceptions to the timely filing limit.
  - Correcting or updating Third Party Liability (TPL) information is located in this chapter.
- Chapter 7 – Specific Policy / Regulation
  - This chapter contains medical services policies that pertain to providers. Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act.
  - This chapter is separated by provider type: Autism Spectrum Disorder, Behavioral Health Clinicians and Psychologist.

Regulations / Policies

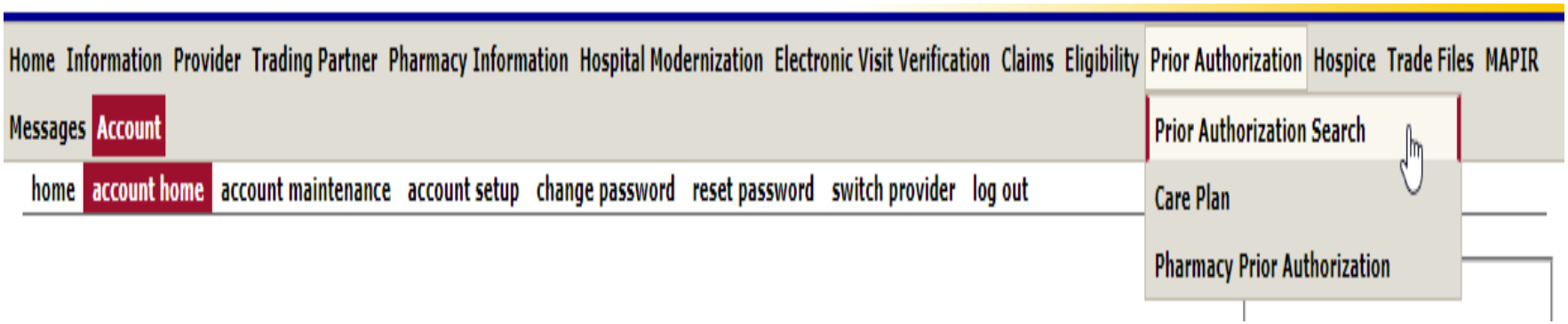
- Provider Manual Chapter 8 - Provider Specific Claims Submission Instructions are located on the www.ctdssmap.com Web site; under Publications, scroll to Provider Manual Chapter 8 and from the drop down select the provider type.

- Provider Manual Chapter 11 - Other Insurance and Medicare billing guide is located on the www.ctdssmap.com Web site; under Publications, scroll to Provider Manual Chapter 11 and select claim type “Professional Other Insurance/Medicare Billing Guide”.

- Provider Manual Chapter 12 – Claim Resolution Guide will provide a detailed description of the cause of each Explanation of Benefit (EOB) code and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition.

Prior Authorization Inquiry

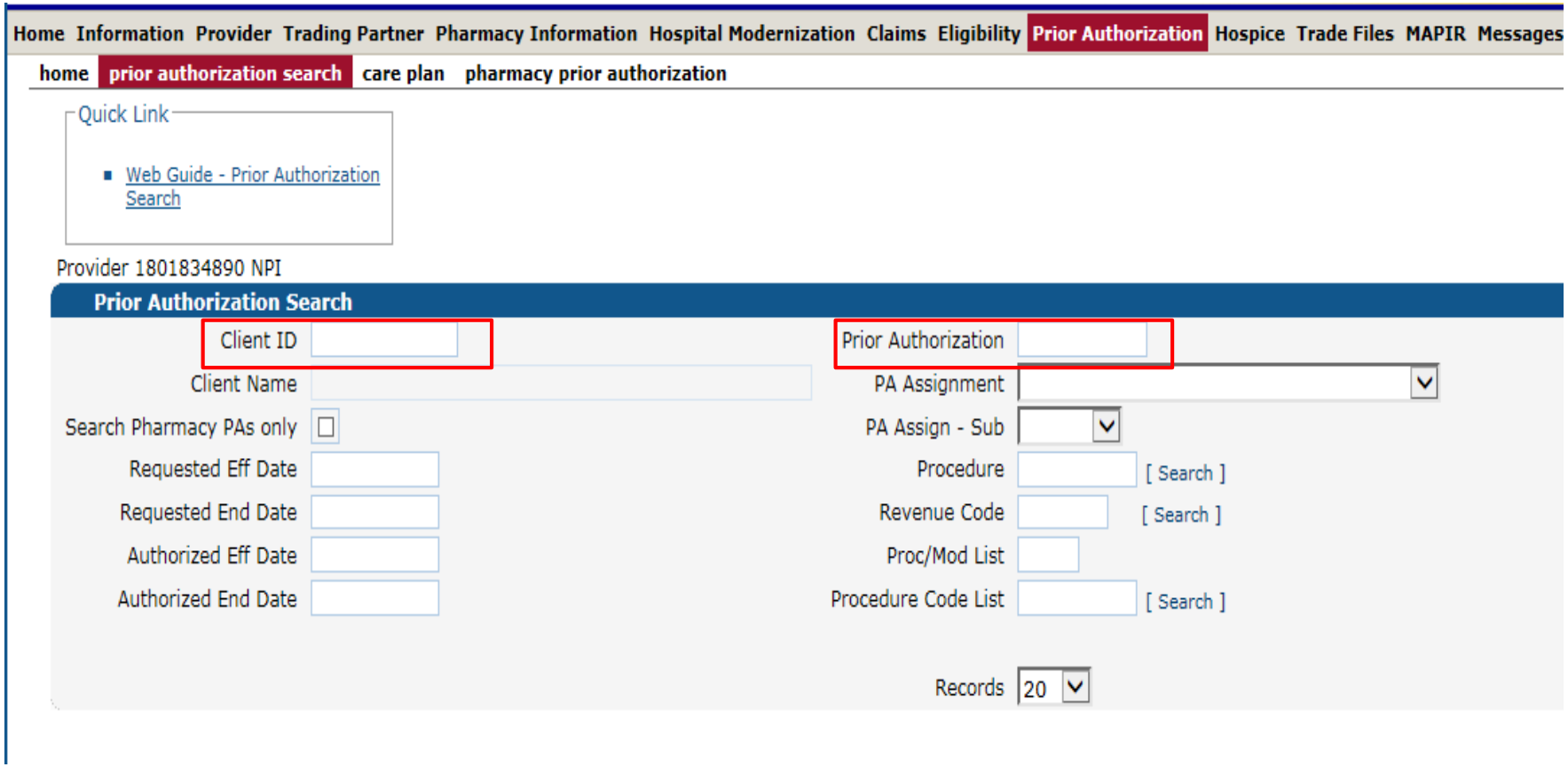
- To view an authorization on www.ctdssmap.com Web site, the provider would have to sign into their secure site, click on “Prior Authorization” and then click on “Prior Authorization Search” on the secure site account home page.



Prior Authorization Inquiry

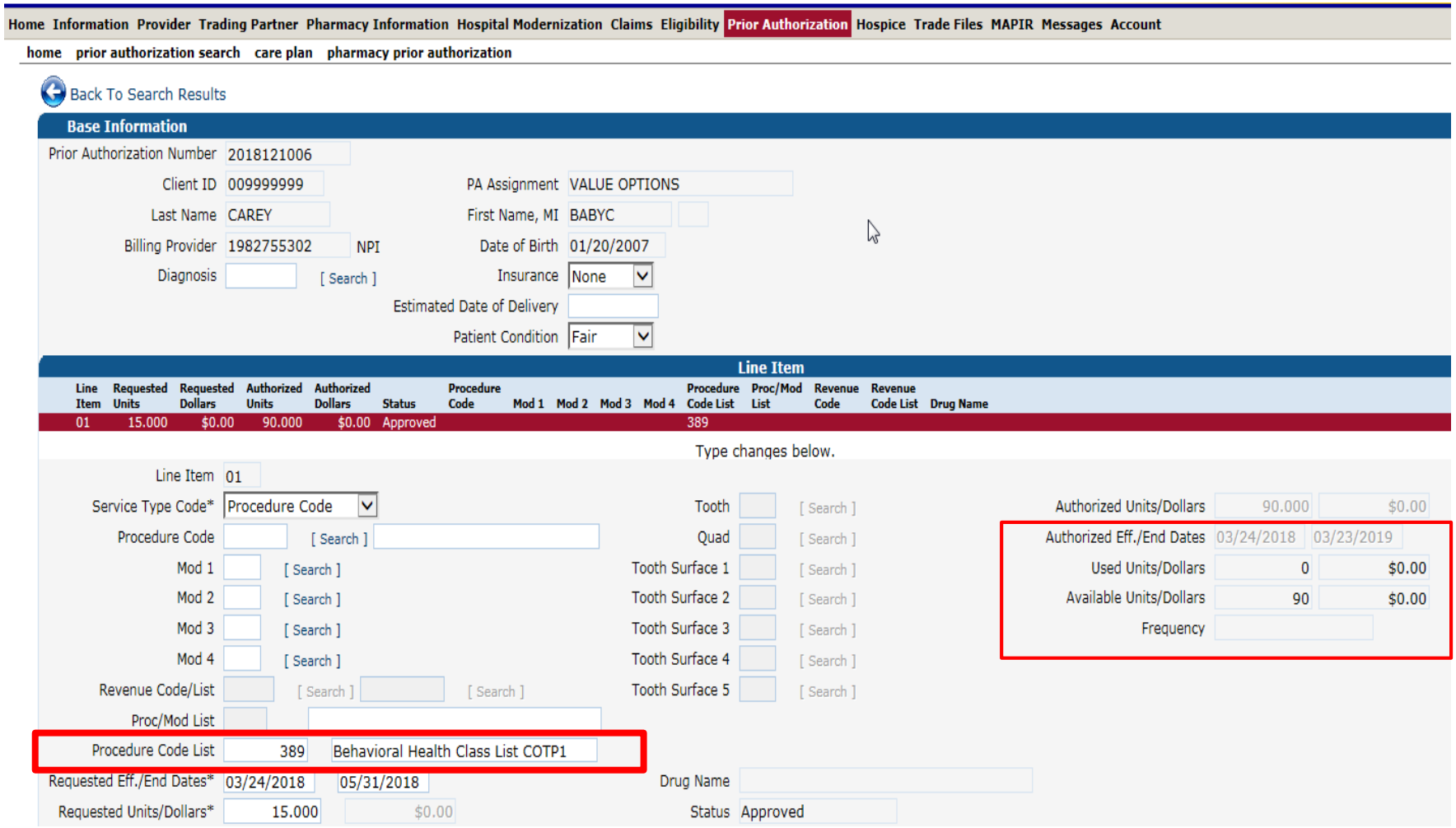
The provider can search for prior authorizations by:

- Client ID
- Prior Authorization Number



Prior Authorization Inquiry

Prior Authorization Example



Prior Authorization Inquiry

CPT/HCPC to Procedure Code List Crosswalk

Description	Billable CPT/HCPC Code	Procedure Code List
Independent Practice	90785, 90791, 90832, 90834, 90837, 90846 - 90847, 90849, 90853, 90875-90876, 90880	389
BH (Autism) – Diagnostic Evaluation	90791, 90791 U5	1196
BH (Autism) – Behavioral Health Assessment	H0031	1197
BH (Autism) – Mental Health Service Plan	H0032	1198
Other BH (Autism) – Treatment Services	H2014, 97153	1199
Other BH (Autism) – Observation and Direction	H0046	1202
Other BH (Autism) – Autism Group Treatment	97153, 97158	1203
Psychological and Neuropsychological Testing	96130-96133, 96136-97137	394, 395
Developmental Screening – Independent Practice	96110, 96112-96113	N/A*

- Developmental Screening prior authorizations will be authorized using the actual procedure code instead of a procedure code list.

Prior Authorization

- As an interim measure in response to the Governor's recent declaration of a public health emergency as the result of the outbreak of COVID-19 DSS is temporarily changing the PA requirements for specified services effective for dates of service April 1, 2020 until DSS has notified providers in writing that the state has deemed COVID-19 to no longer to be a public health emergency (Temporary Effective Period).

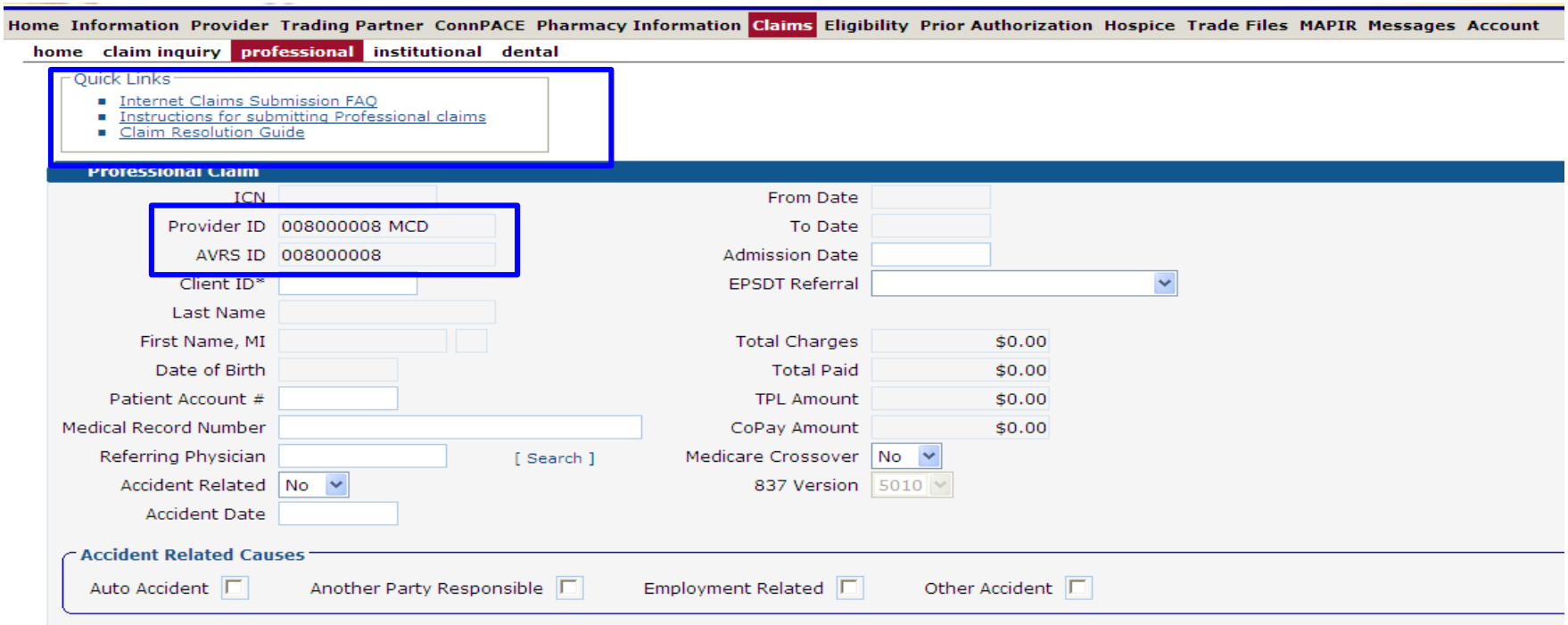
- During the Temporary Effective Period, PA and registration requirements will be waived for the following outpatient behavioral health services:

Description	Billable CPT/HCPC Code
Psychiatric Diagnostic Evaluation	90785 and 90791
Therapies	90832 – 90838, 90846 – 90847, 90849 and 90853

Web Claim Submission

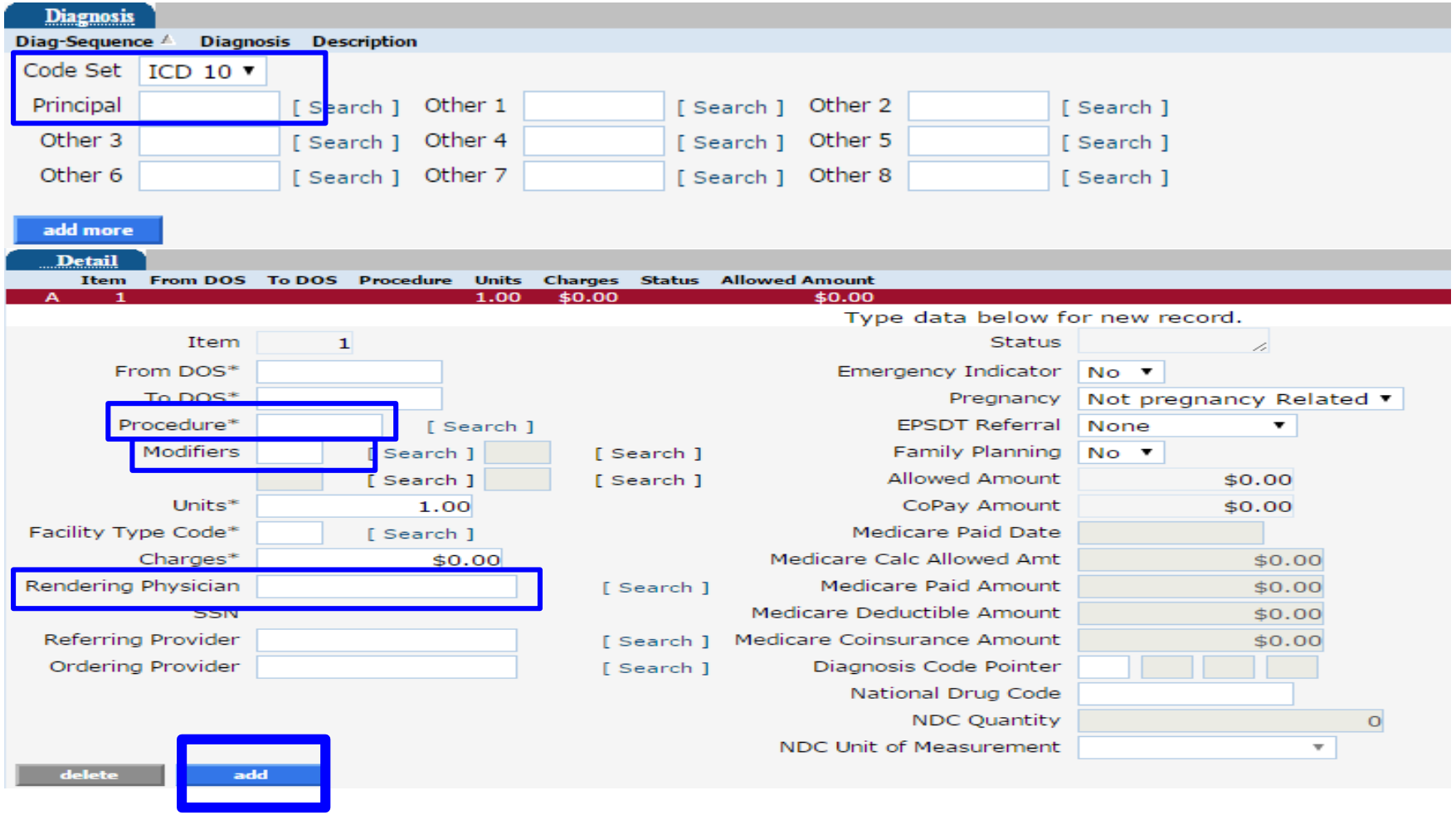
To submit a professional claim using www.ctdssmap.com Web site, click on “Claims” then “professional” on the account home page.

- The “Instructions for submitting Professional claims” document can be referenced when submitting a claim. You can refer to provider manual Chapter 8 for additional claim submission information.



Web Claim Submission

- All required fields are marked with an asterisk.

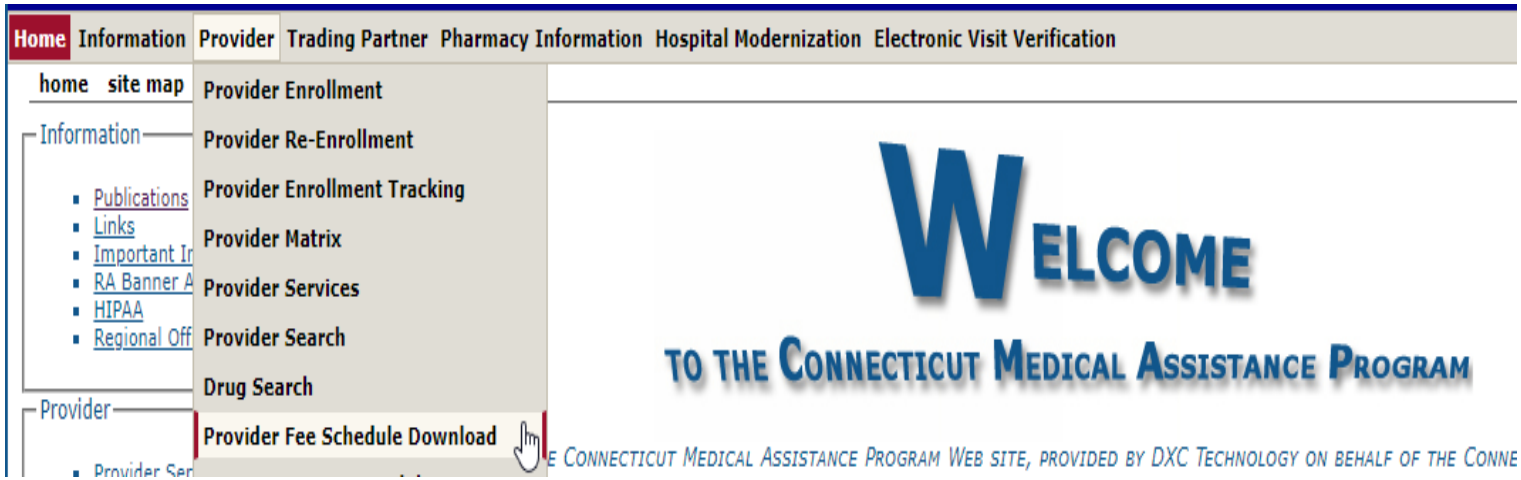


Web Claim Submission

- Diagnosis code – ICD10 diagnosis code.

- Procedure – 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.



Provider Fee Schedule

Psychologists fee schedule

Provider Fee Schedule Download

- Acquired Brain Injury CSV
- Acquired Brain Injury II CSV
- Ambulatory Detoxification CSV
- Autism Spectrum Disorder CSV
- Behavioral Health Clinician CSV
- Chiropractor CSV
- Clinic - Ambulatory Surgical Center CSV
- Clinic - Chemical Maintenance CSV
- Clinic - Clinic and Outpatient Hospital Behavioral Health CSV
- Clinic - Dialysis CSV
- Clinic - Family Planning / Abortion CSV
- Clinic - Medical CSV
- Clinic - Rehabilitation CSV
- Community First Choice - Assessments CSV
- Community First Choice - Services CSV
- CT Home Care CSV
- Dental CSV
- Home Health PDF
- Hospice CSV
- Hospital Outpatient CSV
- Independent Audiology and Speech and Language Pathology CSV
- Independent Physical Therapy and Occupational Therapy CSV
- Independent Radiology CSV
- Lab CSV
- MEDS - DME CSV
- MEDS-Hearing Aid/Prosthetic Eye CSV
- MEDS-Medical/Surgical Supplies CSV
- MEDS-MISC CSV
- MEDS-Parenteral-Enteral CSV
- MEDS-Prosthetic/Orthotic CSV
- Mental Health Waiver CSV
- Natureopath PDF
- Optician/Eyeglasses CSV
- Personal Care Assistant CSV
- Physician Anesthesia CSV
- Physician Office and Outpt Services CSV
- Physician Radiology CSV
- Physician Surgical CSV
- Psychologist CSV

Provider Fee Schedule

Psychologists fee schedule

	Psychologist						

	For all HUSKY Health Benefit Plans T1016 is only payable for clients under						
	_____the age of 19						

Procedure	Description	Mod1	Rate Type	Max Fee	Effective D	End Date	PA
0373T	Adapt bhv tx ea 15 min		DEF	28.2	2/1/2019	12/31/2299	Y
90785	Psytx complex interactive		DEF	3.13	1/1/2013	12/31/2299	Y
90791	Psych diagnostic evaluation		DEF	125.38	1/1/2013	12/31/2299	Y
90791	Psych diagnostic evaluation		FTD	59.72	10/1/2014	12/31/2299	Y
90791	Psych diagnostic evaluation	U5	DEF	612	1/1/2019	12/31/2299	Y
90832	Psytx w pt 30 minutes		DEF	52.28	1/1/2013	12/31/2299	Y
90832	Psytx w pt 30 minutes		FTD	24.9	10/1/2014	12/31/2299	Y
90834	Psytx w pt 45 minutes		DEF	76.64	1/1/2013	12/31/2299	Y
90834	Psytx w pt 45 minutes		FTD	37.32	10/1/2014	12/31/2299	Y
90837	Psytx w pt 60 minutes		DEF	114.91	1/1/2013	12/31/2299	Y
90837	Psytx w pt 60 minutes		FTD	56.36	10/1/2014	12/31/2299	Y
90846	Family psytx w/o pt 50 min		FTM	45.41	10/1/2014	12/31/2299	Y
90846	Family psytx w/o pt 50 min		MPH	75.62	1/1/2012	12/31/2299	Y
90847	Family psytx w/pt 50 min		FTM	54.06	10/1/2014	12/31/2299	Y
90847	Family psytx w/pt 50 min		MPH	93.16	1/1/2012	12/31/2299	Y

- **Modifier U5 – Autism Services**

Provider Fee Schedule

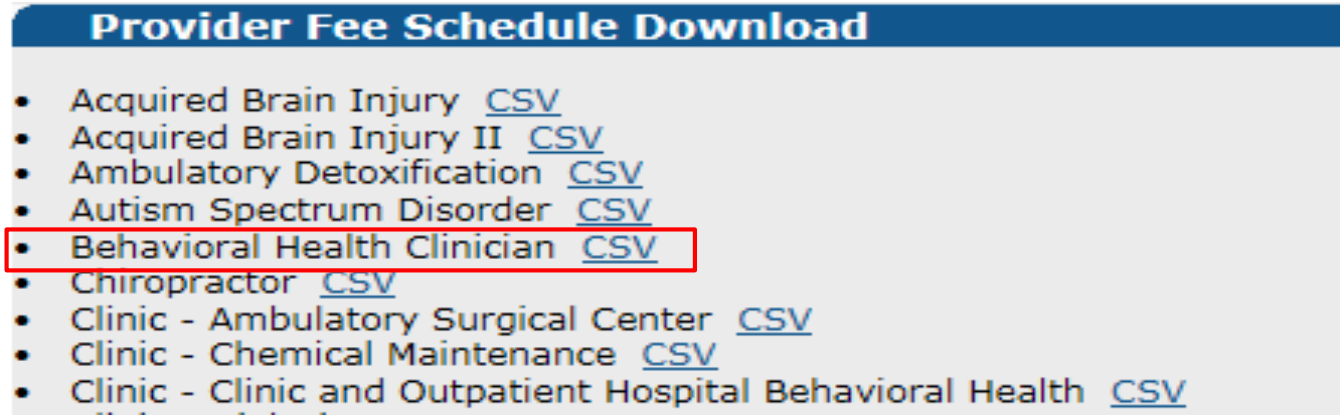
Psychologists fee schedule

99406	Behav chn		FTM	5.98	1/1/2015	12/31/2299	
99406	Behav chn		MPH	6.43	1/1/2012	12/31/2299	
99407	Behav chn		FTM	10.7	1/1/2015	12/31/2299	
99407	Behav chn		MPH	17.56	1/1/2012	12/31/2299	
H0031	Mental He		MPH	95.2	1/1/2015	12/31/2299	Y
H0032	Mental He		MPH	95.2	1/1/2015	12/31/2299	Y
H0032	Mental He	TS	MPH	65.69	7/1/2016	12/31/2299	Y
H0046	Mental he		MPH	23.8	7/1/2016	12/31/2299	Y
H2014	Skills Trai		MPH	16.48	2/1/2016	12/31/2299	Y
T1016	Case man		MPH	12.75	1/1/2012	12/31/2299	
	Please contact Value Options at 1-877-552-8247 for all prior authorizations						
	Codes 96150-96155 are payable only for non-behavioral health diagnoses (those						
	_____not in the ICD-9-CM range 291-316 or not in the ICD-10-CM range in Table 11 of						
	_____the Fee Schedule Instructions)						
	Procedure code 96116 payable effective 01/01/2014						
	Effective 10/1/2014 claims billed with facility type code (FTC) of 31 or 32						
	_____will be paid at a unique rate and identified on the fee schedule with a						
	_____new rate type of FTD or FTM						
	Effective 1/1/15; codes 0359T; H0031; H0032 and H2014 are covered for ages 0 -20.						
	_____Codes can only be provided by the following providers: 33/112 or 86/112.						

- DEF - Default Rate Type
- MPH – Melded Physician Rate Type
- FTD - Facility Default or FTM - Facility Melded Physician (FTM) - Reimbursement when services are rendered in skilled nursing facility or nursing facility.

Provider Fee Schedule

Behavioral Health Clinicians fee schedules



- Behavioral health clinicians can only bill for those services that are on their fee schedule and which they personally provide depending on their specialty.

Provider Fee Schedule

Behavioral Health Clinicians fee schedule

	Behavioral Health Clinician						

	For all HUSKY Health Benefit Plans T1016 is only payable for clients under						
	_____the age of 19						

Procedure	Description	Mod1	Rate Type	Max Fee	Effective D	End Date	PA
0373T	Adapt bhv tx ea 15 min		DEF	23.23	2/1/2019	12/31/2299	Y
90785	Psytx complex interactive		DEF	2.58	1/1/2013	12/31/2299	Y
90791	Psych diagnostic evaluation		DEF	103.25	1/1/2013	12/31/2299	Y
90791	Psych diagnostic evaluation	U5	DEF	504	1/1/2019	12/31/2299	Y
90791	Psych diagnostic evaluation		FTD	49.18	10/1/2014	12/31/2299	Y
90832	Psytx w pt 30 minutes		DEF	43.06	1/1/2013	12/31/2299	Y
90832	Psytx w pt 30 minutes		FTD	20.5	10/1/2014	12/31/2299	Y
90834	Psytx w pt 45 minutes		DEF	63.12	1/1/2013	12/31/2299	Y
90834	Psytx w pt 45 minutes		FTD	30.73	10/1/2014	12/31/2299	Y

- Modifier U5 – Autism Services

Provider Fee Schedule

Behavioral Health Clinicians fee schedule

H0046	Mental health service nos		MPH	19.6	7/1/2016	12/31/2299	Y
H2014	Skills Training and Developme		MPH	13.57	2/1/2016	12/31/2299	Y
T1016	Case management		MPH	10.5	1/1/2012	12/31/2299	

	Please contact Beacon Health Options at 1-877-552-8247 for all prior authorizations						

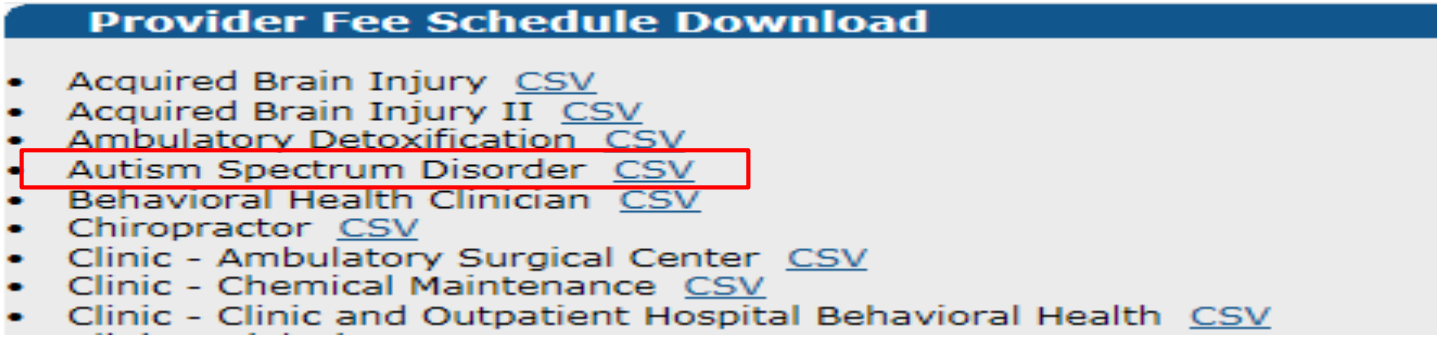
	Effective 10/1/2014 claims billed with facility type code (FTC) of 31 or 32						
	_____will be paid at a unique rate and identified on the fee schedule with a						
	_____new rate type of FTD or FTM						

	Effective 1/1/15; codes 0359T; H0031; H0032 and H2014 are covered for ages 0 -20.						
	_____Code 0359T can only be provided by the following providers: 33/115 or 86/115.						
	_____Codes H0031; H0032 and H2014 can all be provided by: 33/115; 33/119; 33/121;						
	_____86/115; 86/119; or 86/121.						

	For Procedure code 97153; Behavioral Health Clinicians are reimbursed 70% of the						
	_____Department's rate on file of $16.07. When calculating the reimbursement rate						
	_____the system uses the following method $16.07 X 70% = $11.249; $11.249 X # of						
	_____units billed.						

Provider Fee Schedule

Autism Specialist provider fee schedule.



- Autism Specialists can only bill for those services that are on their fee schedule and which they personally provide.

Provider Fee Schedule

Autism Specialist provider fee schedule

	Autism Spectrum Disorder							
Procedure	Proc description	Mod1	Rate Type	Max Fee	Effective I	End Date	QTY	PA
97153	Adaptive behavior treatment by prot		ASD	11.25	1/1/2019	12/31/2299	72	Y
97158	Group adaptive behavior treatment v		ASD	2.75	1/1/2019	12/31/2299	16	Y
H0031	Mental Health Assessment by non-pl		ASD	78.4	1/1/2015	12/31/2299	10	Y
H0032	Mental Health Service Plan Developn		ASD	78.4	1/1/2015	12/31/2299	3	Y
H0032	Mental Health Service Plan Developn	TS	ASD	54.1	7/1/2016	12/31/2299	3	Y
H0046	Mental health services not otherwise		ASD	19.6	7/1/2016	12/31/2299	24	Y
H2014	Skills Training and Development per		ASD	13.58	7/1/2016	12/31/2299	75	Y

- Rate Type “ASD” – Autism Spectrum Disorder
- Modifier “TS” – Follow up Service

Performing Provider Requirements

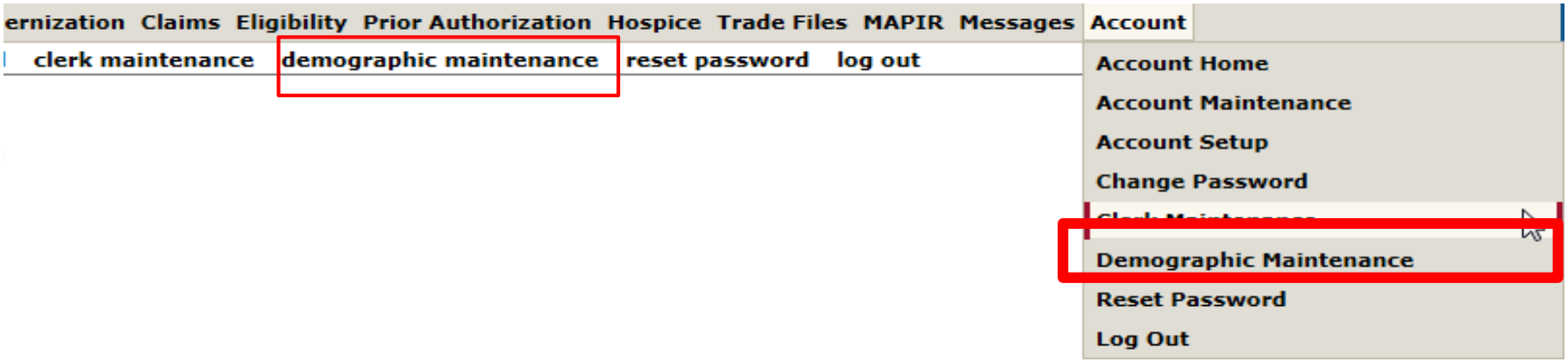
- Rendering Physician – Enter the NPI of the provider who actually performed the service.
  - Required when it is not the same as the billing provider.

- For Autism Specialty Groups, performing providers will be required on your claims effective for dates of Service June 1, 2020 and forward.

- Non-enrolled performing providers need to be enrolled in CMAP.
  - Providers may use the DXC Technology Provider Enrollment Wizard located at www.ctdssmap.com to enroll. From the Home page, go to “Provider”, then “Provider Enrollment”. Using the Enrollment Wizard, each provider not currently enrolled must choose to be enrolled as an “Individual practitioner” or “Employed/Contracted by an organization” and select the provider type.
  - “Individual practitioners”, as well as all “Employed/Contracted by an organization” providers, will need to complete the “Members of Organization Panel” during the enrollment process if they are working in a behavioral health group (BH clinician, psychologist or Autism Specialist group) in order to associate themselves to the group they are a member.

Performing Provider Requirements

- Providers already actively enrolled in CMAP, but need to be associated to a group.
  - For organization members who are already actively enrolled, behavioral health groups are required to associate their members to their behavioral health group. The organization provider can use the “Maintain Organization Members” panel to view, separate or add members to their organization.
  - Once logged in to their secure Web portal, the primary account (also referred to as a master user) can associate individual providers to their group. It is the organization’s responsibility to maintain proper member associations within their organization.

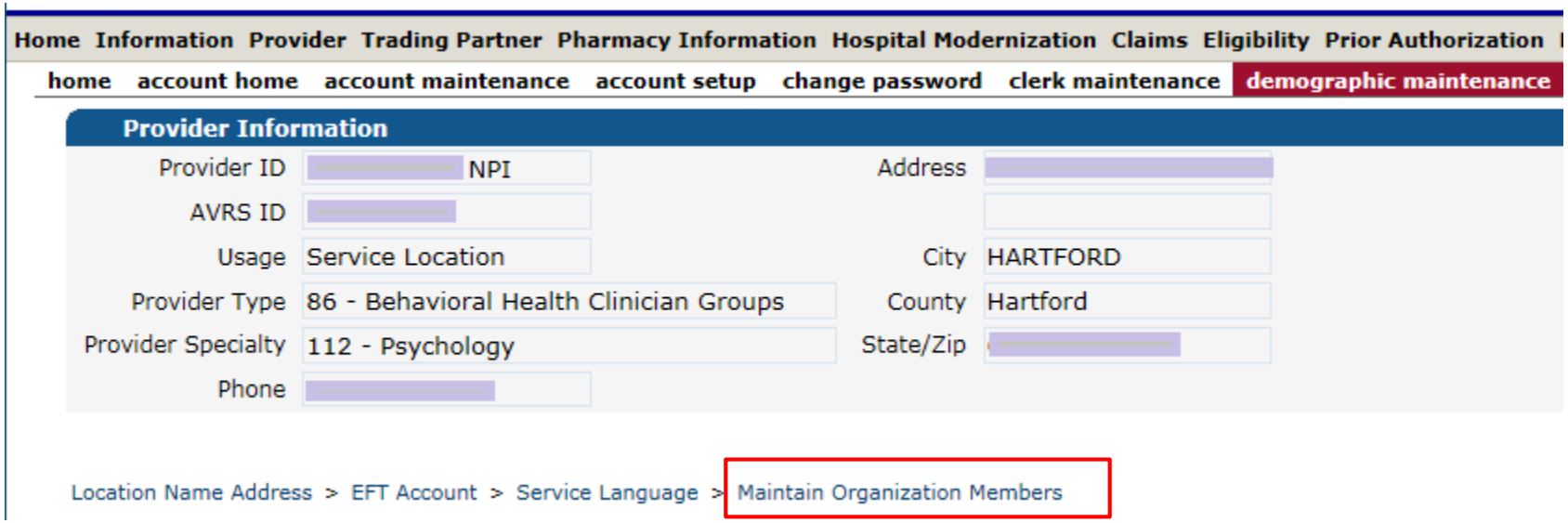


Performing Provider Requirements

Maintain Organization Members.

- Group providers must associate all their individual providers to the group through the group's secure Web portal account.

- Failure to associate providers to their group practices could cause claim denials.



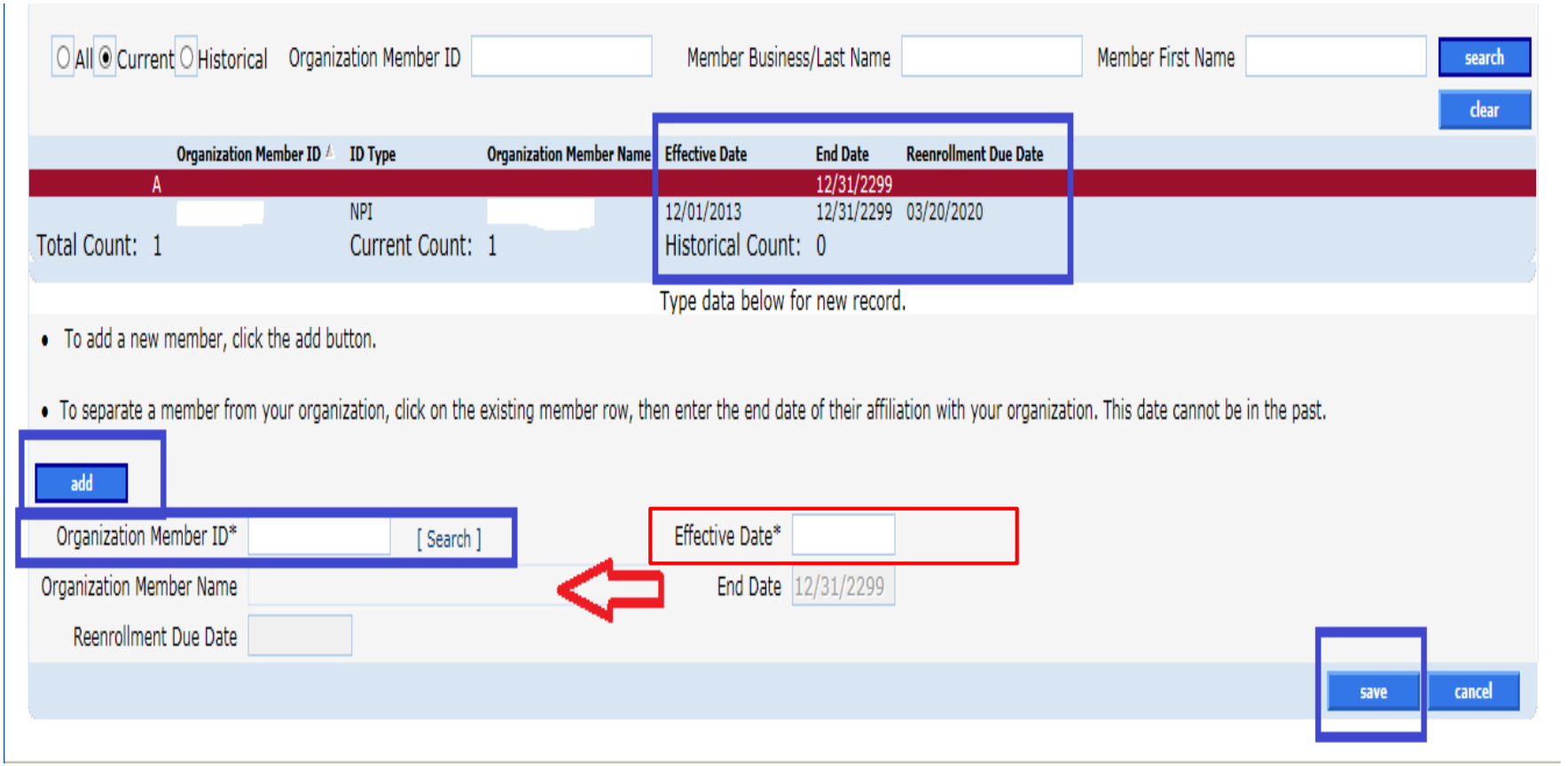
Performing Provider Requirements

To add a new member:

- Click the Add button.
- Enter the practitioner's NPI under Organization Member ID field.
  - It should auto-populate with the provider's name.
- Enter the effective date you want the individual provider association to begin. The effective date can be up to 6 months prior to the date you are adding the member.
  - The end date will be automatically populated with the date 12/31/2299.
- Click Save.

Performing Provider Requirements

Add a new member



Performing Provider Requirements

To remove or end a provider’s affiliation with your group:

- Click on the existing member.
- Enter the end date of their affiliation with the group in the end date field.
  - The end date cannot be a date in the past.
- Click Save.

Performing Provider Requirements

- Technicians
  - "Technician" means an individual who provides direct Autism Spectrum Disorder (ASD) treatment services under the supervision of a licensed practitioner or BCBA in accordance with section 17b-262-1058 of the Regulations of Connecticut State Agencies.
  - Technicians cannot enroll in Medicaid; in this instance, the supervising licensed practitioner or BCBA should be enrolled in Medicaid and the Autism Specialist group is required to bill with the BCBA provider as the performing provider.

Additional information on the requirements for enrolling performing providers for Autism Specialist Groups can be found in provider bulletin 2020-08 "Performing Providers Required for Autism Specialist Group."

Web Claim Submission

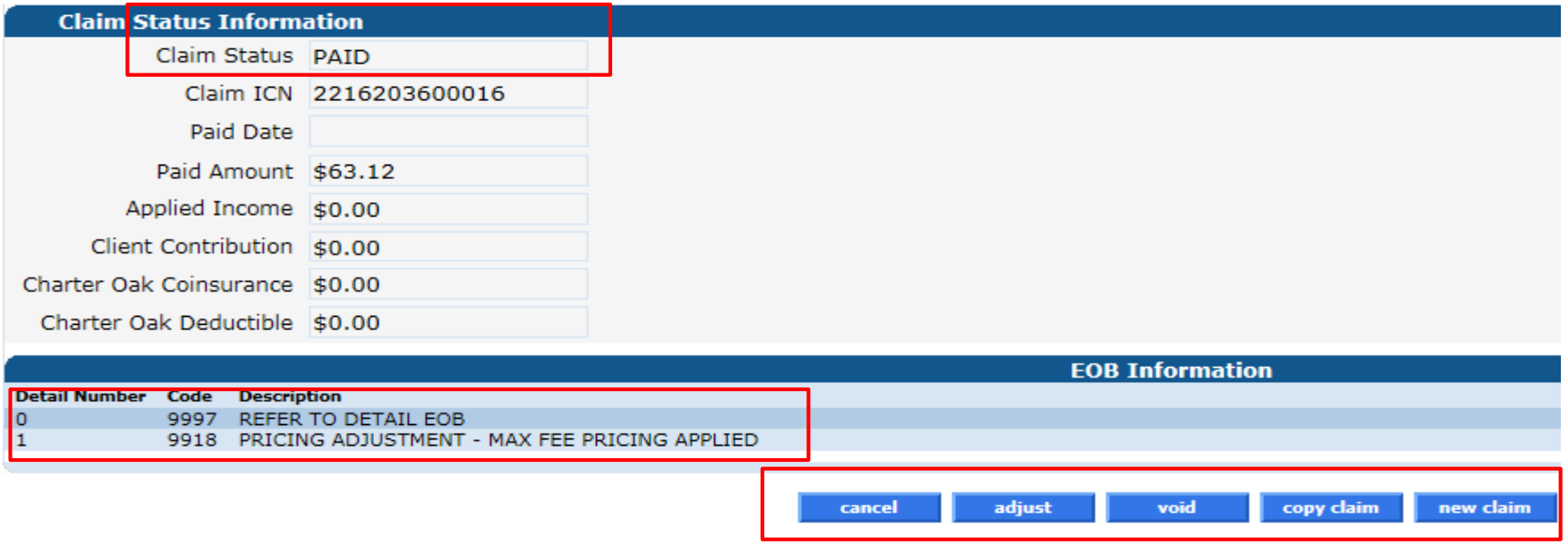
- Modifiers – The following providers must bill with the corresponding modifiers.

Provider Type / Specialty	Modifier
License Clinical Social Worker (LCSW)	AJ
Licensed Marital and Family Therapists (LFMT)	HO
Licensed Professional Counselors (LPC)	HO
Licensed Alcohol and Drug Counselors (LADC)	HO

Web Claim Submission

Once all information is entered on your claim, hit submit to submit your claim to DXC Technology.

Response from DXC Technology is immediate.



Web Claim Submission

Error Messages - If required information is missing, the self editing feature of Web claims generates error messages to alert the provider and will prevent the claim from being submitted until the errors have been corrected.

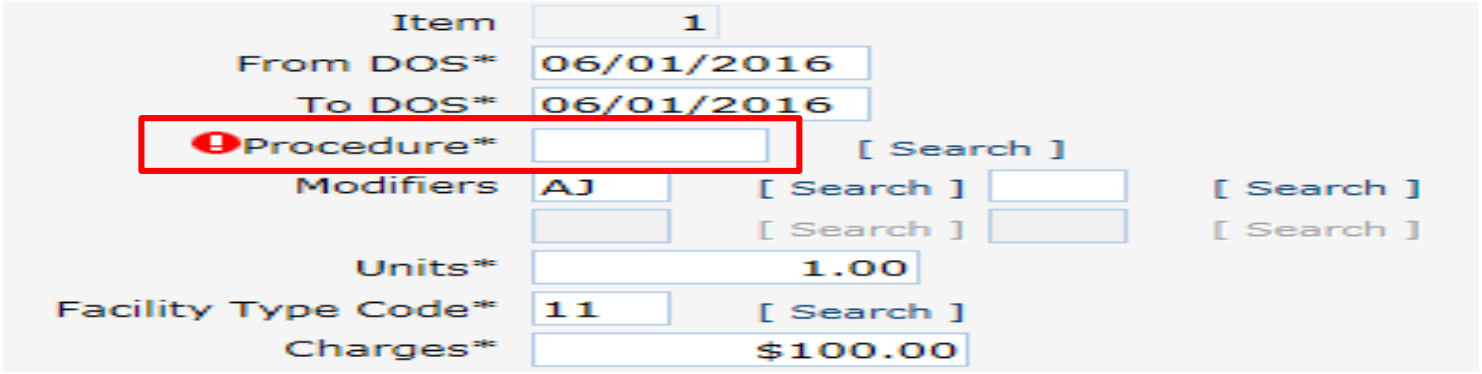
The following messages were generated:

Message Description	Panel	Field	Row
Procedure is required.	Detail	Procedure	1
A valid Procedure is required	Detail	Procedure	1

The error message will point to the Panel, the Field and the Row where the error has occurred.

Detail

	Item	From DOS	To DOS	Procedure	Units	Charges
A	1	06/01/2016	06/01/2016		1.00	$100.00



Web Claim Submission

What does the following error mean: “Processing failed due to a communication error?”

- This error means that the communication between DXC Technology and the provider either failed in the delivery of the claim to DXC Technology, or in the claim status response back to the provider. It is recommended that a claim inquiry be performed on the claim to determine if the claim successfully processed in interChange.

  - If the claim is not present on the Web after a claim inquiry, then the claim should be resubmitted.

Web Claim Adjustment

Perform the following steps to easily adjust a paid claim:

- Select Claim Inquiry.
- Perform search to find your claim and click the search button.
- Once the claim is retrieved, make any necessary changes to the claim.
- Click the adjust button at the bottom of the claim page.

Web Claim Adjustment

The following are web claim adjustments that can be submitted through the secure Web site www.ctdssmap.com.

- Claims that are not past timely filing.
  - Timely filing guidelines are one (1) year from the date of the most recent Remittance Advice (RA).
  - For additional timely filing guidelines, providers can refer to Provider Manual Chapter 5 “Claim Submission Information.”

- Claims past timely filing that will pay the same or less than the original claim can be adjusted.

Web Claim Adjustment

The following are adjustments that cannot be submitted through the secure Web site www.ctdssmap.com.

- Adjusting claims that are past timely filing that are allowed more monies.
  - If the provider tries to adjust these claims, they will be denied for timely filing and the original payment will be recouped.

- Adjusting claims that are past timely filing, but the services are modified, even if they pay the same or less.
  - If the provider tries to adjust claims using different procedure codes, it will deny for timely filing.

- Claims with an ICN that begin with either 12 or 13 were specially handled by DXC Technology. The provider should contact DXC Technology before attempting to adjust these claims on the Web.

- Medicare Crossovers
  - Crossover claims cannot be adjusted; they must be voided, copied and then submitted as new claims.

Web Claim Submission – Third Party Liability (TPL)

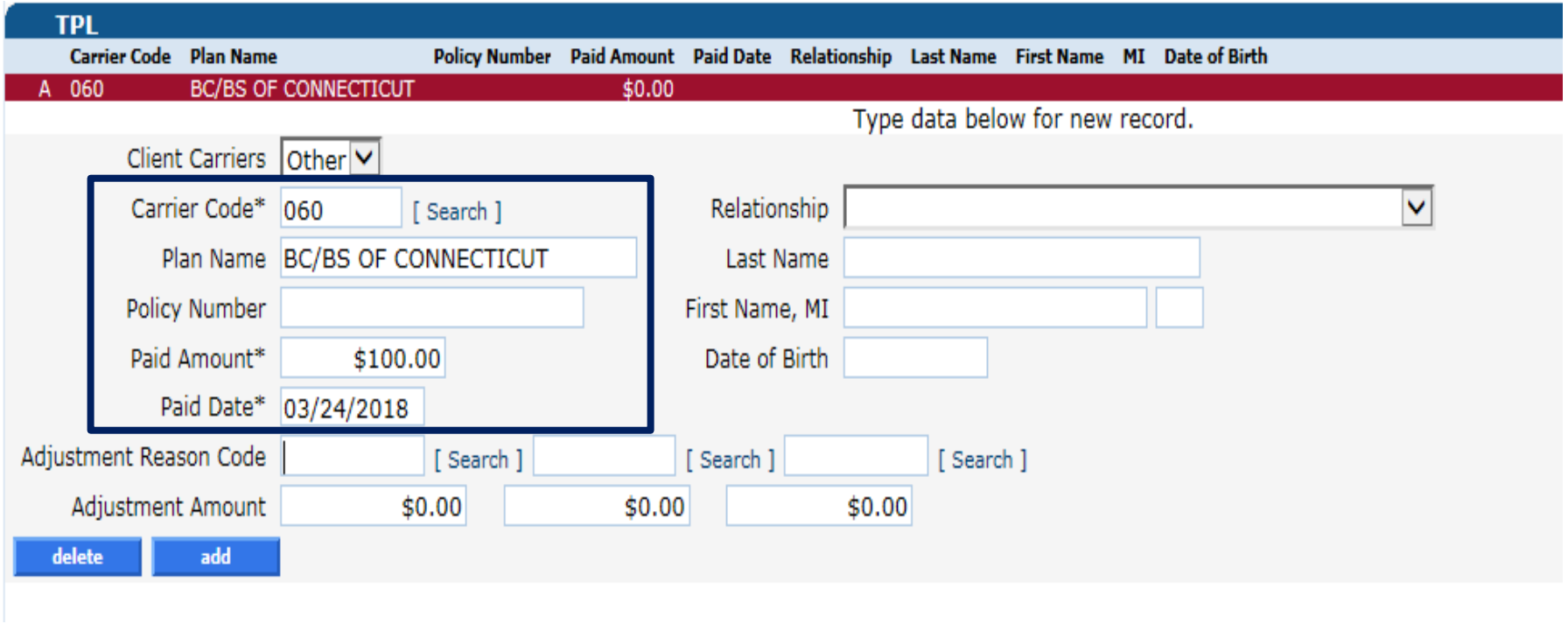
Medicaid is the payer of last resort. If the client has Other Insurance, the provider is required to submit their claim to the primary carrier for coverage prior to submitting their claim to Medicaid.

Submission requirements:

- The three digit Carrier Code of the other insurance is required to be submitted on the claim when submitting as secondary to Medicaid.
  - The three digit code can be found on the client eligibility verification screen under TPL (Third Party Liability).
  - It can also be found on the claim submission screen under the TPL panel in the “Client Carriers” field.
- Providers would need to include on the claim the other insurance paid amount (If other insurance denied the claim, enter $0.00) and the date of other insurance payment or denial.

Web Claim Submission - TPL

TPL payment of $100.00 from carrier code 060 with a paid date of 03/24/2018.



Web Claim Submission – Medicare Payment

Dual Eligible is when a client is eligible for Medicare and Medicaid. Medicaid is always the payer of last resort and claims must be submitted to Medicare first for Medicare eligible services.

Medicare refers to traditional Medicare and Medicare HMOs (Managed Care).

- If Medicare is the primary payer and makes a payment, DSS will pay co-insurance and/or deductible up to your Medicaid rate.

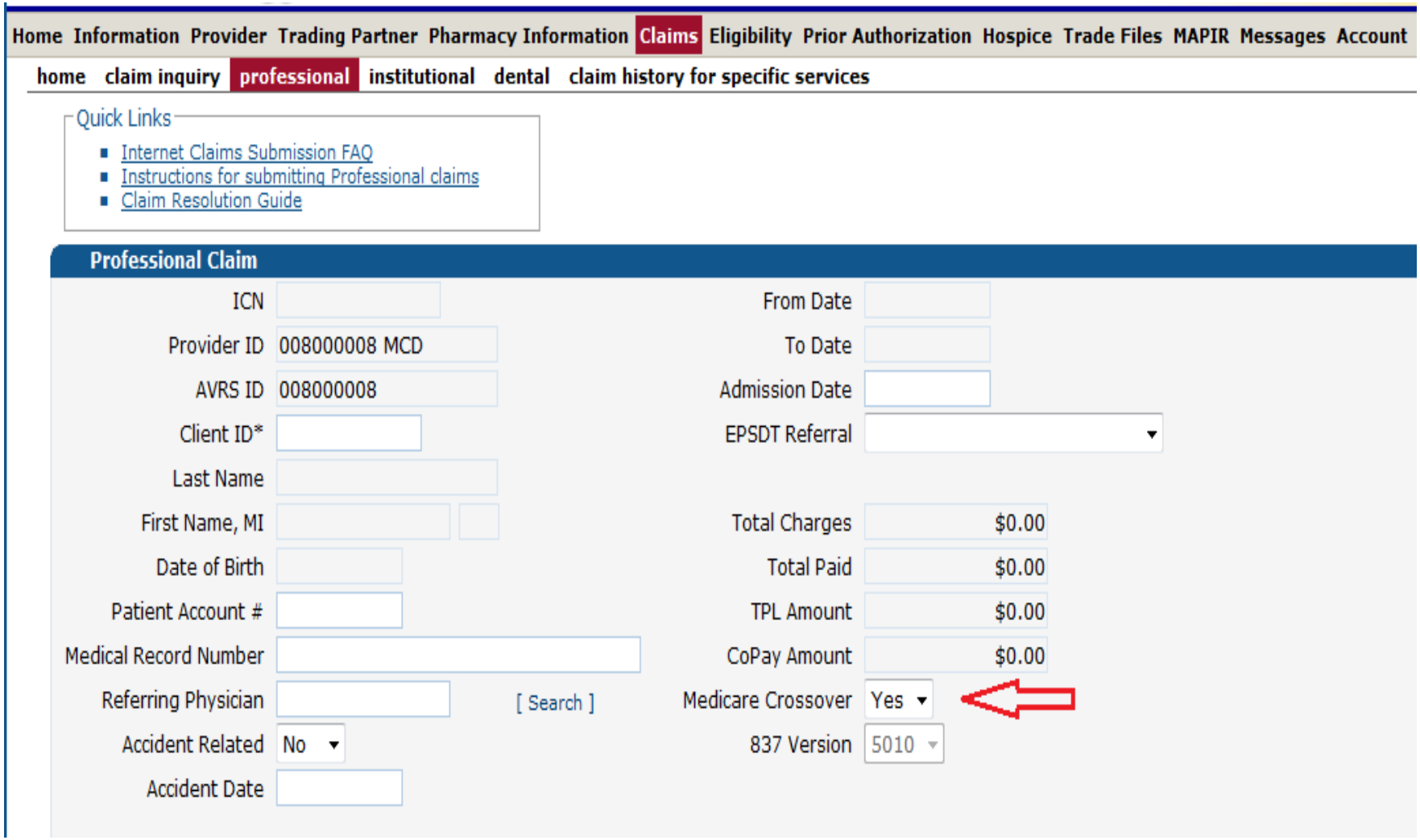
  - If Medicare's payment is greater than or equal to your Medicaid rate, Medicaid will pay zero.
    - In this case, the client should not be billed for Medicare's co-insurance and/or deductible.

Web Claim Submission – Medicare Payment

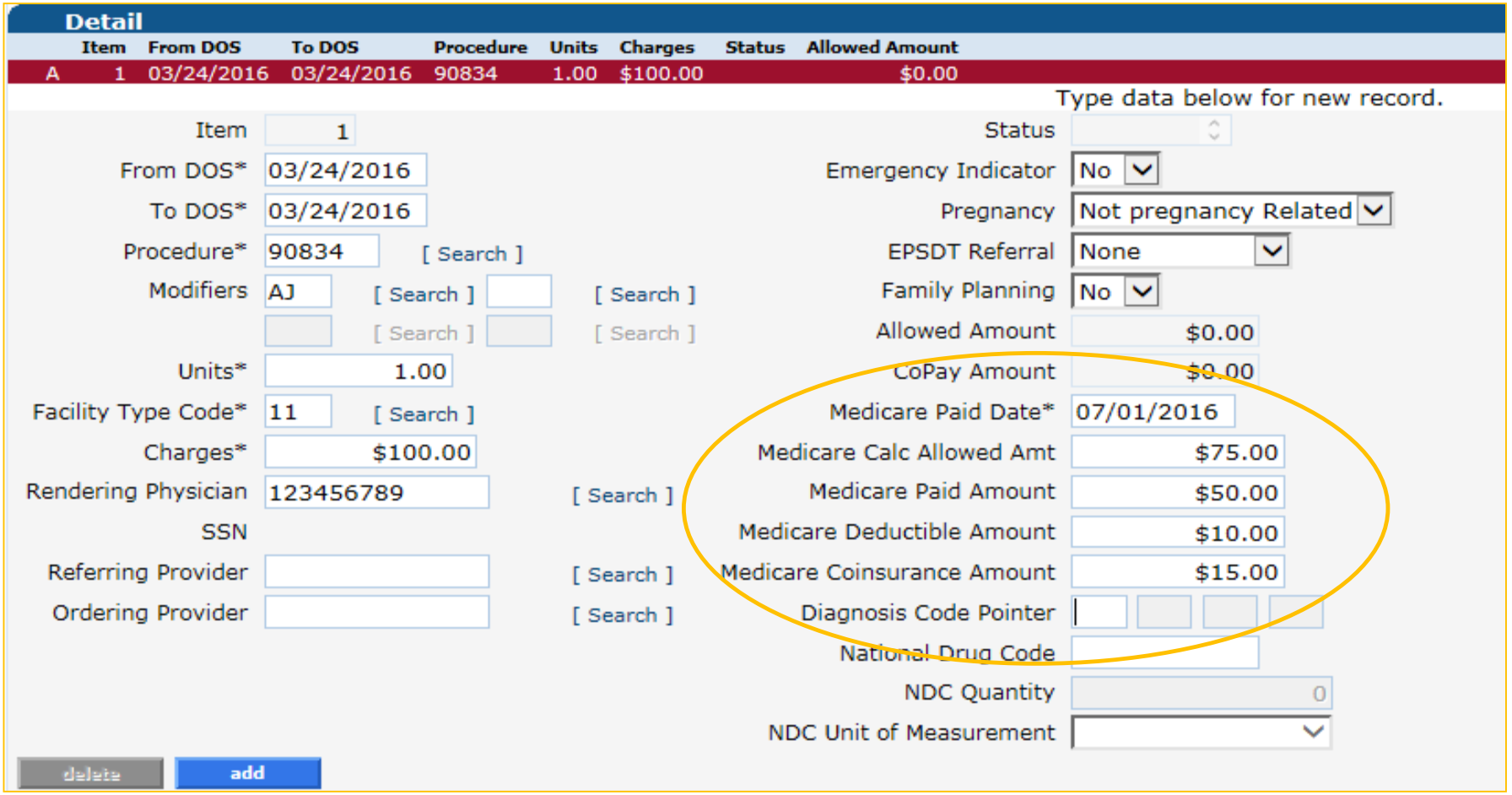
To indicate a Medicare payment, the Medicare Crossover field on the Professional Claim panel must indicate Yes.

- Each claim detail must contain the following:
  - Medicare Paid Date
  - Medicare Calculated Allowed Amount
  - Medicare Paid Amount
    - If Medicare allows services but pays zero, enter $0.00.
  - Medicare Deductible Amount
  - Medicare Coinsurance or Co-pay Amount

Web Claim Submission – Medicare Payment



Web Claim Submission – Medicare Payment



Web Claim Submission – Medicare Denial

- If Medicare does not cover services due to the fact that behavioral health clinicians cannot enroll in Medicare (Medicare traditional plans), Medicaid will still consider your claim for processing.

- If the provider cannot get a denial Explanation of Medicare Benefits (EOMB), the provider should receive a letter from Medicare/CMS stating they are not eligible to enroll in Medicare and the letter must be dated within one year from the date of service on the claim.

- To request this letter, providers must submit a request in writing to National Government Services (NGS) at PO Box 7052, Indianapolis, Indiana 46207-7052.

- In lieu of the Medicare 'Not Eligible To Enroll' denial letters for behavioral health clinician providers requested through NGS, providers may submit a copy of the list of suppliers not eligible to participate in Medicare as valid Medicare denial documentation.

Web Claim Submission – Medicare Denial

- The list is documented in the Medicare Provider Integrity Manual, Publication # 100-8, under Chapter 15, Section 15.4.8 which is located on the CMS Web site, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf.

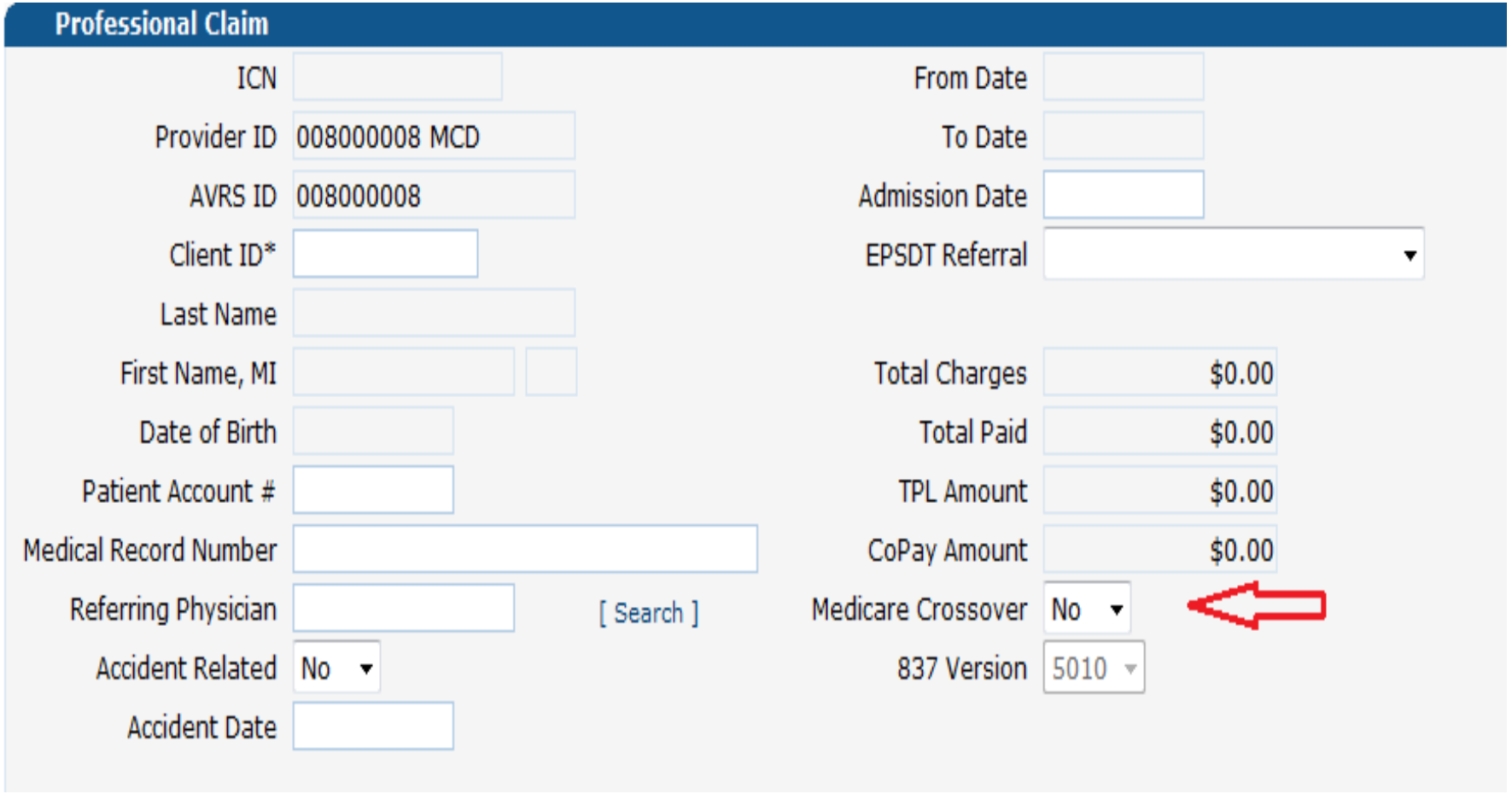
  - A copy of this page must be stored in the client's file for audit purposes and does not need to be submitted with the claim to DXC Technology.

Web Claim Submission – Medicare Denial

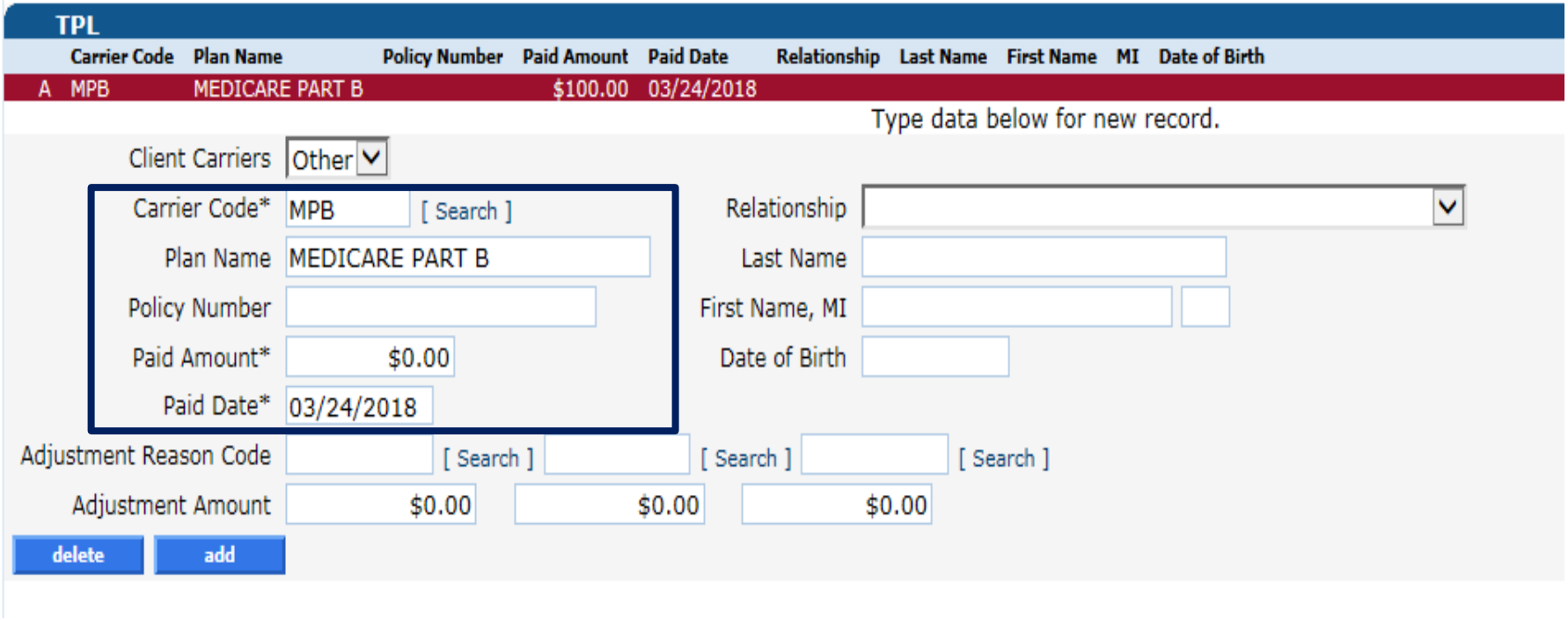
To indicate a Medicare denial, the Medicare Crossover field on the Professional Claim panel must indicate No.

- The TPL panel must contain the following:
  - Enter MPB for Medicare Part B in the Carrier Code field.
  - Zero should remain in the Paid Amount field.
  - In the Paid Date field, enter one of the following:
    - Enter the Medicare denial date.
    - Date of the Medicare letter.
    - The print date of the Medicare CMS Web page documenting the list of providers not eligible.

Web Claim Submission – Medicare Denial



Web Claim Submission – Medicare Denial



Frequent Claim Denials

Explanation of Benefits (EOB) code 4140 “The Services Submitted are not Covered Under the Client’s Benefit Plan” and EOB code 4250 “No Reimbursement Rule for the Associated Provider Type/Provider Specialty.”

- The provider should verify client eligibility to determine if services are covered under the client’s benefit plan for their provider type and specialty.

- If the services are covered under client’s benefit plan, client eligibility could have been updated at some point.

  - Providers should re-submit the claim for processing.

  - If the claim still denies, the provider will need to contact the Provider Assistance Center (PAC) to review the claim.

Frequent Claim Denials

EOB code 4149 “Billing Provider not Authorized to Bill for Submitted Procedure Code.”

- Cause
  - The provider is not authorized to bill for that procedure code.

- Resolution
  - If the procedure billed is not on the provider's fee schedule for the date of service, the service is not payable.

  - If the procedure billed is present on the provider's fee schedule, contact the Provider Assistance Center to request an update to the procedure code in question.

Frequent Claim Denials

EOB Code 4821 “Facility Type is Restricted for Procedure under Provider Contract.”

- Cause
  - The provider provided services in an invalid place of service. A behavioral health clinician or psychologist billed for an invalid facility type code for their provider specialty.
  - Example: The provider bills with a facility type code of 22 “Outpatient Hospital.” In this case, the service would deny with EOB 4821.
- Resolution
  - Verify the facility type code; if billed incorrectly, correct and re-submit the claim.
  - If the facility type code is correct, then the claim denied appropriately.

Frequent Claim Denials

EOB Code 1010 “Performing Provider is Not a Member of the Billing Provider Group.”

- Cause
  - The rendering provider billed on the claim is not associated to the billing group.

- Resolution
  - The provider group needs to associate the rendering provider to their behavioral health group.
  - Once the performing provider is associated to the group, re-submit the claim.

Frequent Claim Denial

EOB code 5925 “CCI column 1 code or mutually exclusive code was billed on the same date as previous column 2 code.”

EOB code 5926 “CCI column 2 code or mutually exclusive code was billed on the same date as previous column 1 code.”

Cause

- A claim containing a CCI column 1 or 2 code or mutually exclusive code was submitted for the same date of service as a previously paid CCI column 1 or 2 code.

Resolution

- Verify the procedure code and date of service information on the claim. If the data was keyed incorrectly, make the necessary corrections and resubmit the claim. If the data was keyed correctly, the claim is not payable based on a previously paid claim.

For detailed information regarding the National Correct Coding Initiative, please review Provider Bulletins PB 2011-12, PB 2011-41, and PB 2012-40.

National Correct Coding Initiative (NCCI)

Procedure-to-procedure (PTP) edits

PTP edits are defined as pairs of HCPCS/CPT codes that should not be reported together on the same date of service for a variety of reasons and prevent reimbursement for both procedures.

- Visit the CMS Web site https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html for:
  - How to look up PTP code edits.
  - Use of bypass modifiers.

National Correct Coding Initiative (NCCI)

- Medicaid NCCI Procedure-to-Procedure (PTP) edits have a single column 1/column 2 correct coding edit (CCE) file.

CPT on	opyright 2017 American Medical Association. All rights reserved.								
Column1/Column 2 Edits									
Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale			
90847	90832		20141001	*	1	CPT Manual or CMS manual coding instructions			
90847	90834		20141001	*	1	CPT Manual or CMS manual coding instructions			

- **For some code pairs when indicated by modifier 1 “Allowed”, a modifier may be used to bypass CCE.**
- **If Modifier 0 “not allowed”, then the procedure code in column 2 will not be allowed even if billed with a modifier.**

Training Session Wrap Up

For questions on prior authorizations and the prior authorization process, please contact:

- Beacon Options 1-877-552-8247

For questions on eligibility, claims (denials or payments), provider enrollment or the provider's fee schedule you should contact:

- DXC Technology Provider Assistance Center (PAC) 1-800-842-8440

If providers are experiencing extended call wait times when calling PAC, providers may email the Provider Assistance Center with their question at ctdssmap-provideremail@dxc.com. Please be sure to include your name and phone number with your inquiry.

Where to go for more information:

- www.ctdssmap.com (DXC Technology)

- www.ctbhp.com (Beacon Health Options)

Time for Questions

Questions & Answers

Thank you.