July 18, 2017

Connecticut Medical Assistance Program Professional Refresher Workshop

Presented by
The Department of Social Services & DXC Technology

DXC.technology

Training Topics

- **Demographic Maintenance**
- **Eligibility Verification**
- **Prior Authorization/Pharmacy Web Prior Authorization**
- **Professional Web Claim Submission**
- **National Correct Coding Initiative (NCCI)**
- **Claim Resolution Guide**
- **DSS Audit Criteria**
- **Provider Fee Schedule**
- **Bulletins**
- **Re-Enrollment**
- **Announcements**
- **Wrap Up and Questions**

Demographic Maintenance

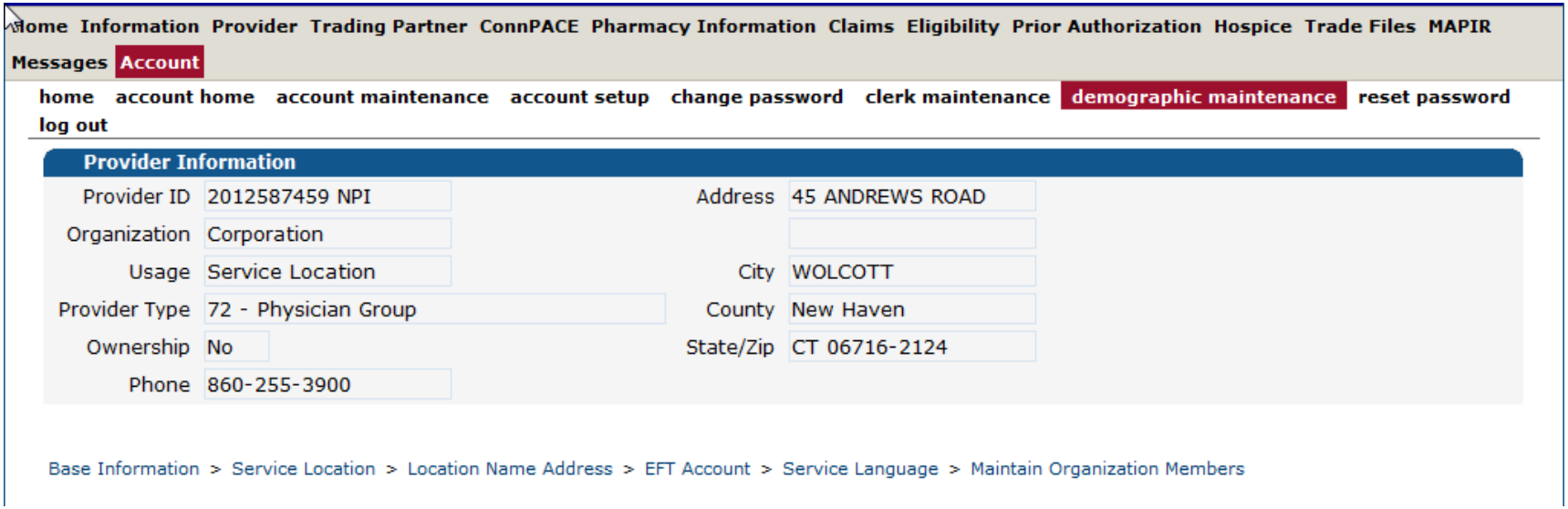
The Department of Social Services (DSS) requires a majority of providers to enroll / re-enroll on our Web site www.ctdssmap.com

- A majority of the required information is automatically populated based on the provider's previous contract information
- Online re-enrollment cannot be initialized until an *Application Tracking Number* (ATN) is received from the DXC Technology Provider Enrollment Unit

Select *Provider Enrollment* from either the *Provider* box on the left hand side of the home page or from the *Provider* drop-down menu; select *Provider Re-Enrollment* from the *Provider* drop-down menu

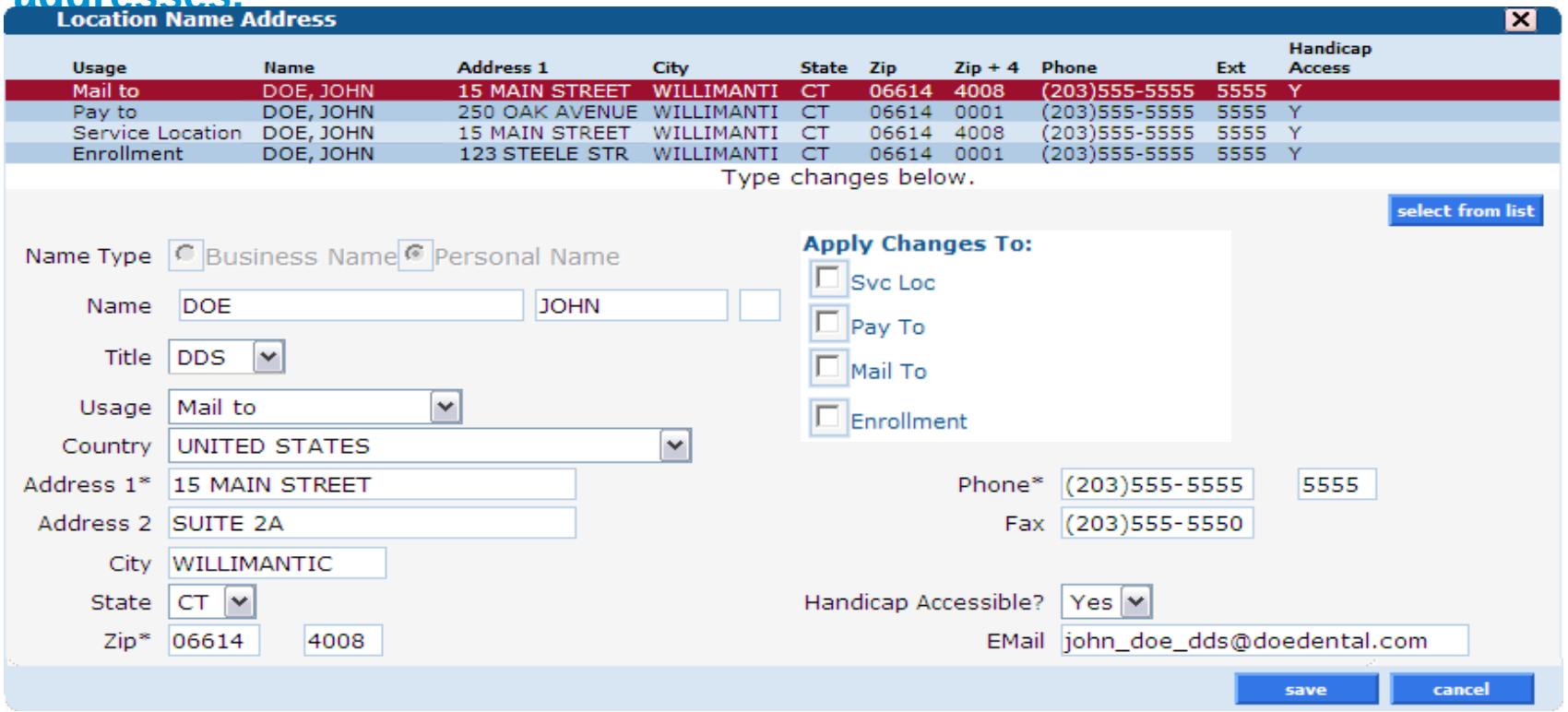
Demographic Maintenance

DSS requires providers to update their demographic information via their secure Web account. Demographic information includes provider addresses, Electronic Funds Transfer (EFT) and member of organization maintenance. The main account administrator must log on to their account and click on the "Demographic Maintenance" tab. See Chapter 10 of the Provider Manual for more information.



Demographic Maintenance – Address Updates

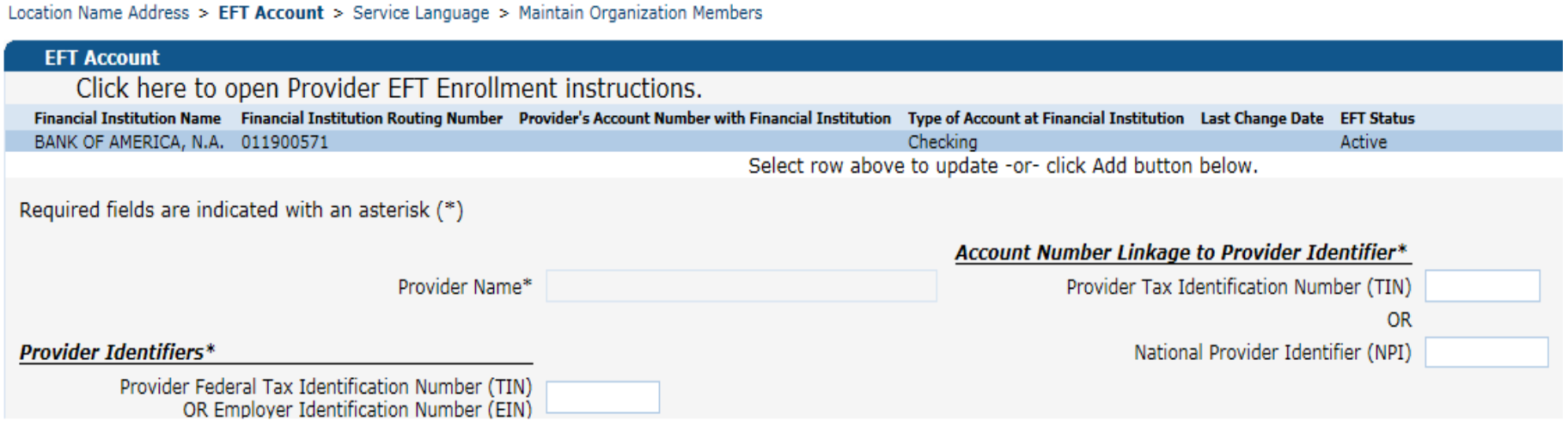
Specify different mailing, payment, service location, and enrollment addresses.



Demographic Maintenance – EFT Updates

The *EFT Account* panel allows you to add and maintain bank accounts into which reimbursements from CMAP will be electronically deposited.

- Click **"*add*"**; enter the appropriate information; and click **"*save*"**

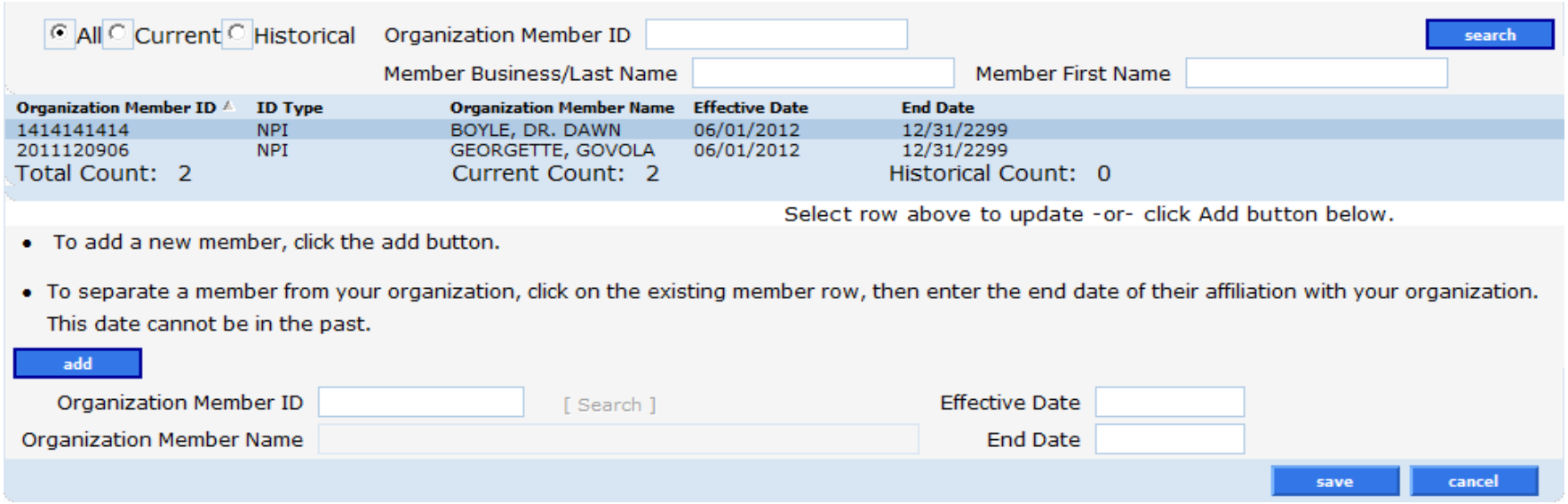


****This action will place the provider in a *pre-notification* status****

Demographic Maintenance – Maintain Organization Members

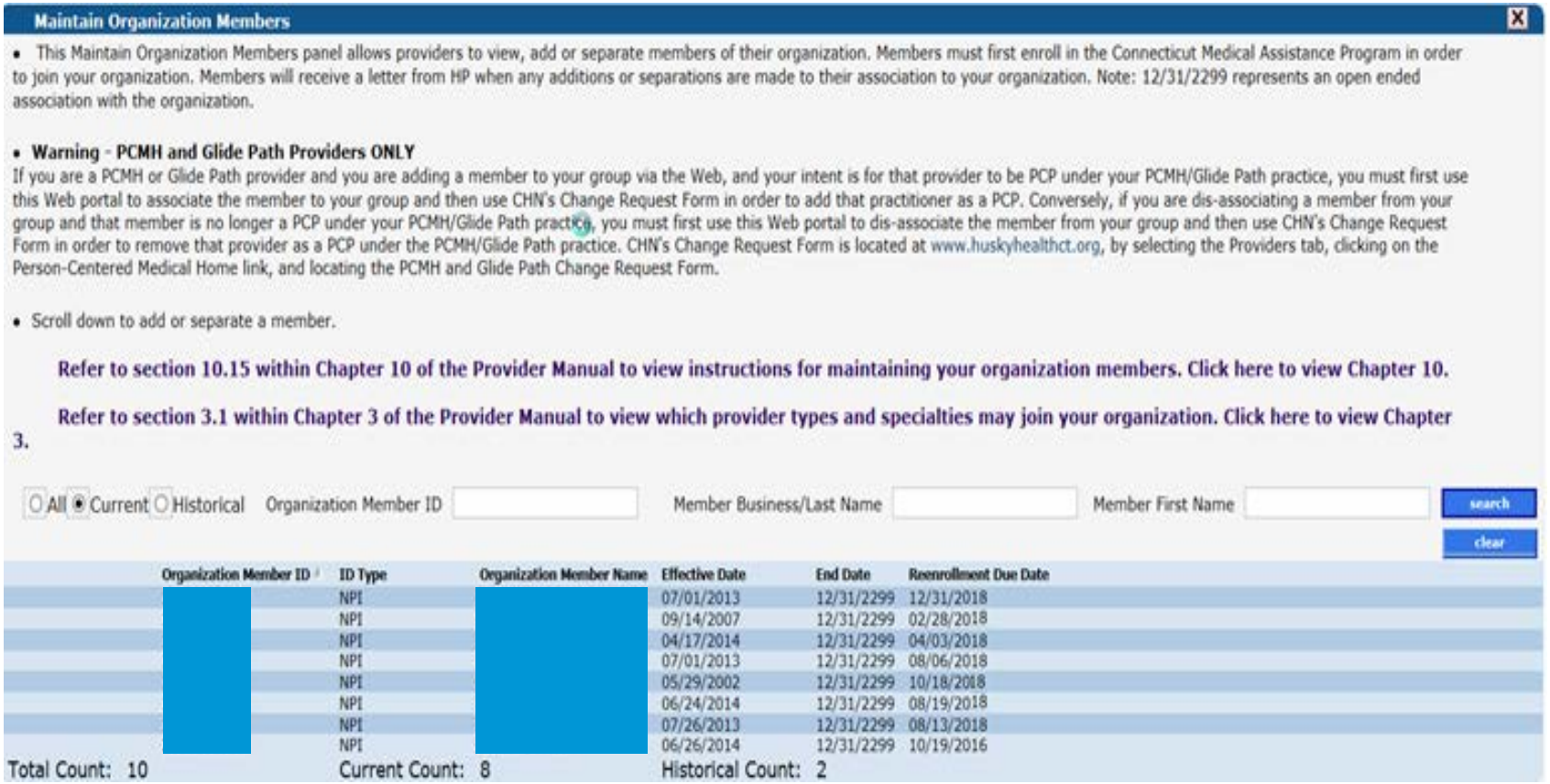
The *Maintain Organization Members* panel allows you to:

- Search current or historical members using the search button
- Add new members by entering their *Organization Member ID* (NPI) as well as *Effective Date*
- Separate members by selecting their *line* and entering an *End Date*



Demographic Maintenance – Maintain Organization Members

Re-Enrollment due dates are visible on the maintain organization panel.



Maintain Organization Members

- This Maintain Organization Members panel allows providers to view, add or separate members of their organization. Members must first enroll in the Connecticut Medical Assistance Program in order to join your organization. Members will receive a letter from HP when any additions or separations are made to their association to your organization. Note: 12/31/2299 represents an open ended association with the organization.

- **Warning - PCMH and Glide Path Providers ONLY**

If you are a PCMH or Glide Path provider and you are adding a member to your group via the Web, and your intent is for that provider to be PCP under your PCMH/Glide Path practice, you must first use this Web portal to associate the member to your group and then use CHN's Change Request Form in order to add that practitioner as a PCP. Conversely, if you are dis-associating a member from your group and that member is no longer a PCP under your PCMH/Glide Path practice, you must first use this Web portal to dis-associate the member from your group and then use CHN's Change Request Form in order to remove that provider as a PCP under the PCMH/Glide Path practice. CHN's Change Request Form is located at www.huskyhealthct.org, by selecting the Providers tab, clicking on the Person-Centered Medical Home link, and locating the PCMH and Glide Path Change Request Form.

- Scroll down to add or separate a member.

Refer to section 10.15 within Chapter 10 of the Provider Manual to view instructions for maintaining your organization members. Click here to view Chapter 10.

Refer to section 3.1 within Chapter 3 of the Provider Manual to view which provider types and specialties may join your organization. Click here to view Chapter 3.

All | Current | Historical Organization Member ID Member Business/Last Name Member First Name search clear

Organization Member ID	ID Type	Organization Member Name	Effective Date	End Date	Reenrollment Due Date
[redacted]	NPI	[redacted]	07/01/2013	12/31/2299	12/31/2018
	NPI		09/14/2007	12/31/2299	02/28/2018
	NPI		04/17/2014	12/31/2299	04/03/2018
	NPI		07/01/2013	12/31/2299	08/06/2018
	NPI		05/29/2002	12/31/2299	10/18/2018
	NPI		06/24/2014	12/31/2299	08/19/2018
	NPI		07/26/2013	12/31/2299	08/13/2018
	NPI		06/26/2014	12/31/2299	10/19/2016

Total Count: 10 Current Count: 8 Historical Count: 2

Eligibility Verification

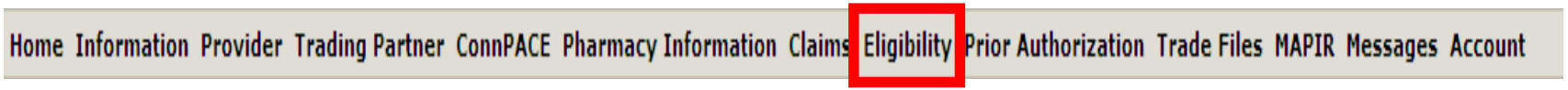
DSS recommends that providers verify a client's eligibility on the date of service *prior to performing said service* because eligibility can change at any time.

Eligibility verification can be performed in the following ways:

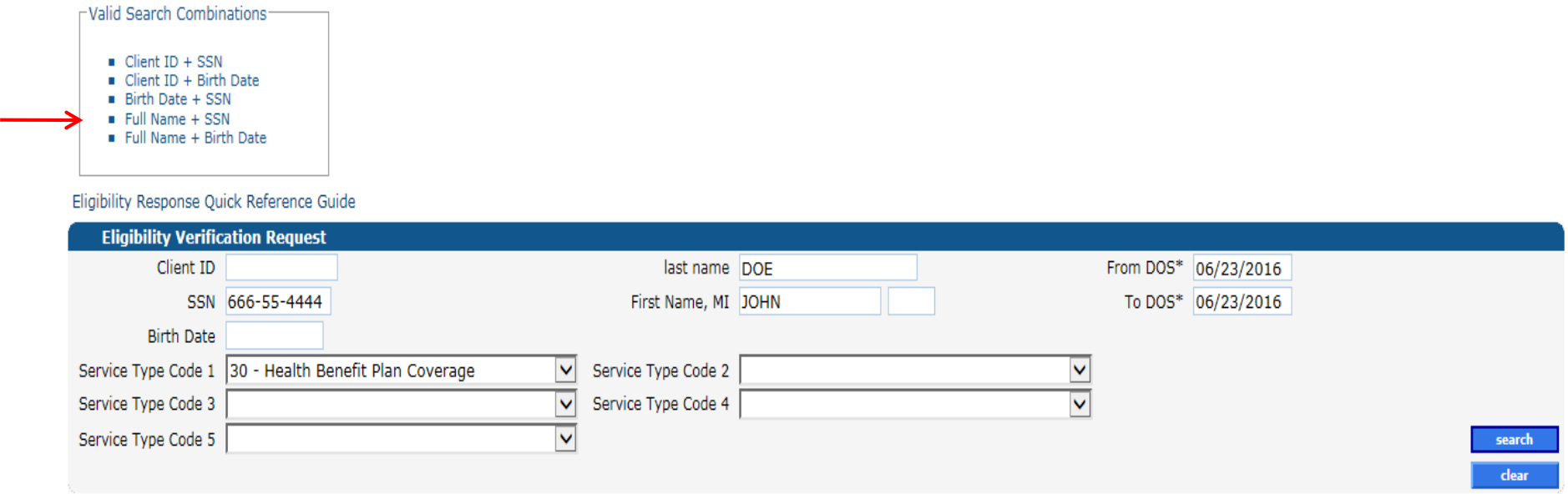
- Internet Web site at www.ctdssmap.com
- Automated Voice Response System (AVRS)
- Point of Sale (POS) Device
- Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction
- Via e-Prescribing using SureScripts and the ASC X12N 270/271 transaction

Eligibility Verification

To verify a CMAP client's eligibility through the secure site – click on the *Eligibility* tab on the main menu.



Enter enough data to satisfy at least one of the *valid search combinations;* click *search*



When entering a full name as part of your search, a middle initial is required if present in their CMAP profile

Prior Authorization Information

DXC Technology accepts prior authorization requests for:

- Home Care Program for Elders- completed by Access Agencies though the Care Plan Portal
- Home Health- Money Follows the Person
- Pharmacy

CHNCT accepts prior authorization requests for:

- Outpatient Hospital Rehabilitation Therapy
- Home Care Services
- Vision Care Services
- Physical Therapy, Occupational Therapy, and Speech Therapy
- Medical Equipment, Devices, and Supplies (MEDS)
- Laboratory Procedures (including genetic testing)
- Outpatient Surgery
- Non-Behavioral Health Clinics
- Palivizumab (Synagis®) Request

Beacon Health Options accepts prior authorization requests for:

- Behavioral Health Services

Prior Authorization Information

Prior authorization forms are located online:

www.ct.gov/husky Click "*For Providers" → "Provider Bulletins, Updates and Forms" → "Outpatient Authorization Request Form"*

- Authorization requests may be submitted to CHNCT via either:
  - *Clear Coverage* online portal www.ct.gov/husky click on "*For Providers",* then *"Clear Coverage"*
  - Phone: 1-800-440-5071 (Monday through Friday, 8 a.m. to 7 p.m.)
  - Fax: 203-265-3994

www.ctdssmap.com

- Go to "*Information" → "Publications" → "Authorization/Certification Forms" → "Prior Authorization Request Form"*
- The DXC Technology fax number for PA submission depends upon the type of authorization being requested; refer to the form for the correct fax number

Professional Web Claim Submission

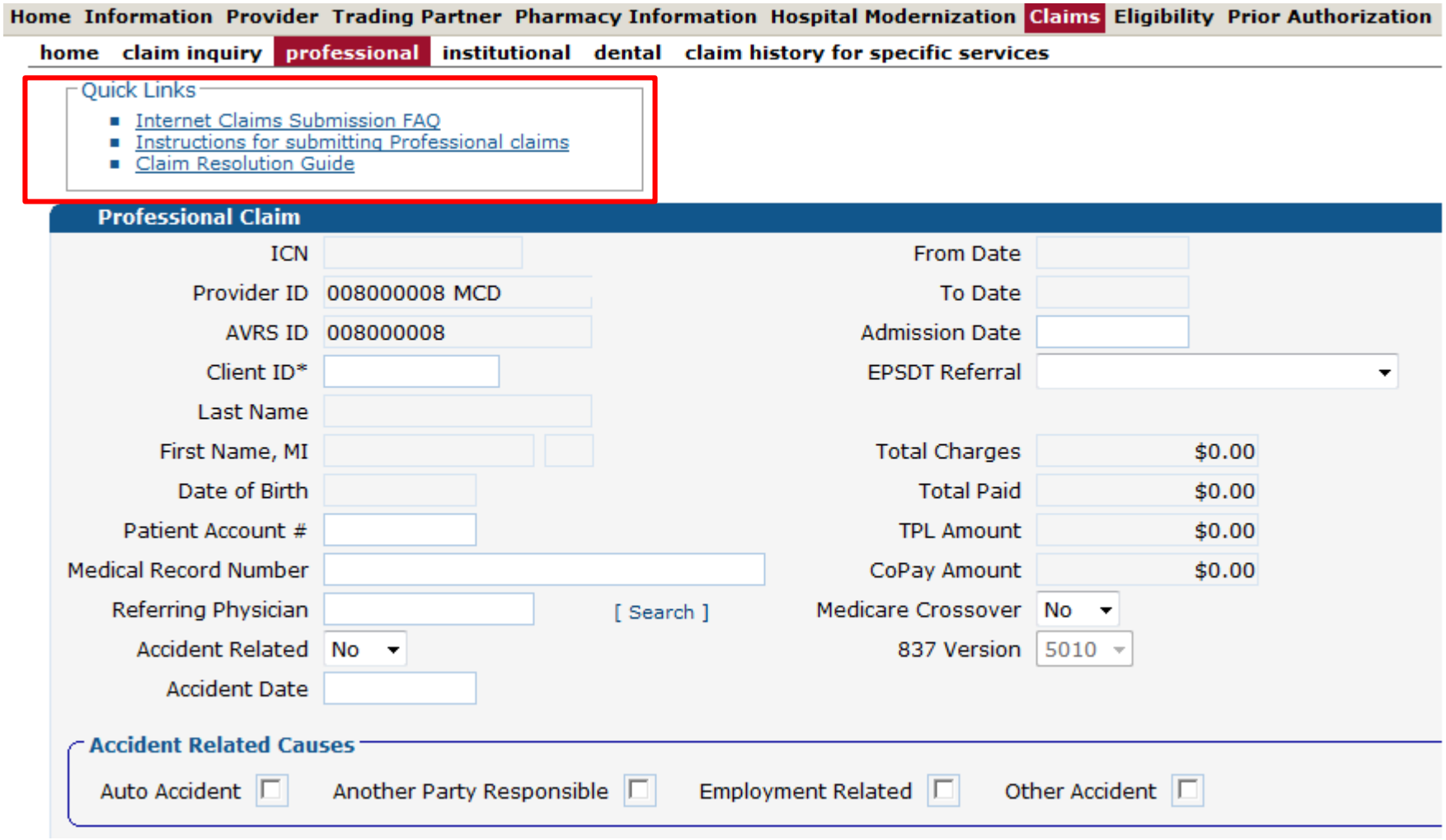
Professional claims can be submitted through the secure Web site by signing into www.ctdssmap.com.

- Once on the secure site, select Professional from the claims drop-down menu.

Claim types that can be submitted through the secure Web site www.ctdssmap.com:

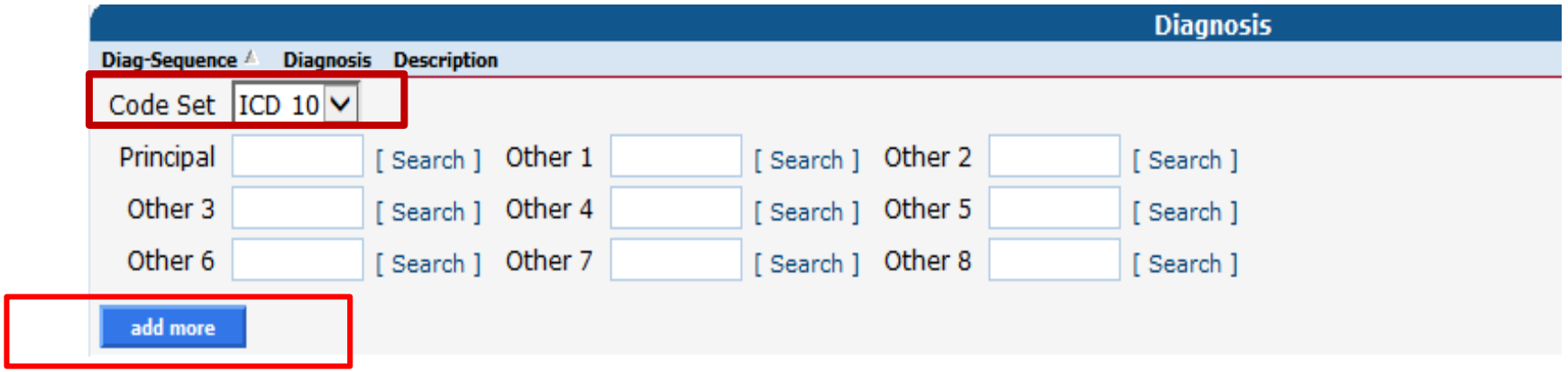
- **Primary and Secondary/Third Party Liability (TPL) claims.**
- **Re-submission and adjustments for non-crossover claims, if they are within timely filing.**
- **Recoup/Void a claim at any time regardless of timely filing.**

Professional Web Claim Submission



Professional Web Claim Submission

- Enter up to 12 Diagnosis codes on a professional claim, click the add more button to enter more than 9.



Professional Web Claim Submission

Professional claim submission instructions are located on the Web site, www.ctdssmap.com, by selecting "Information", then "Publications", and scrolling to the Provider Manual section. From the Chapter 8 drop down box, choose the appropriate provider type.

Procedure Code - Enter the appropriate procedure code for the service performed.

- Refer to the Provider Fee Schedule for procedure code(s) covered in the Connecticut Medical Assistance Program.

Modifier - Enter the corresponding modifier based on rendering provider or services being performed.

- Refer to Provider Manual chapter 8 for a list of modifiers.

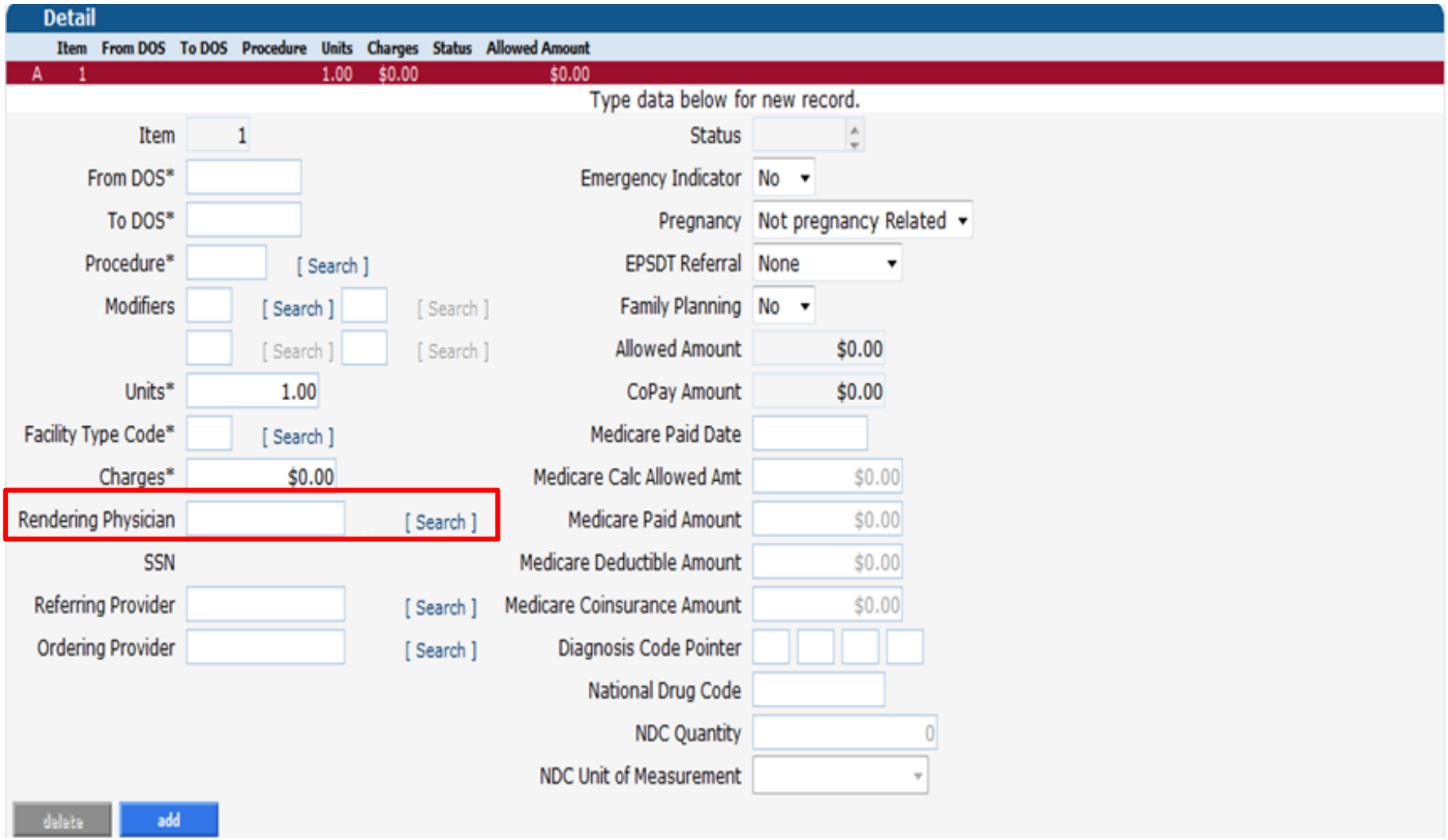
Professional Web Claim Submission

Facility Type Code (FTC), also known as Place of Service (POS) code

Rendering Physician – Enter the NPI of the provider providing the services.

- Rendering providers need to be associated to their practitioner group.

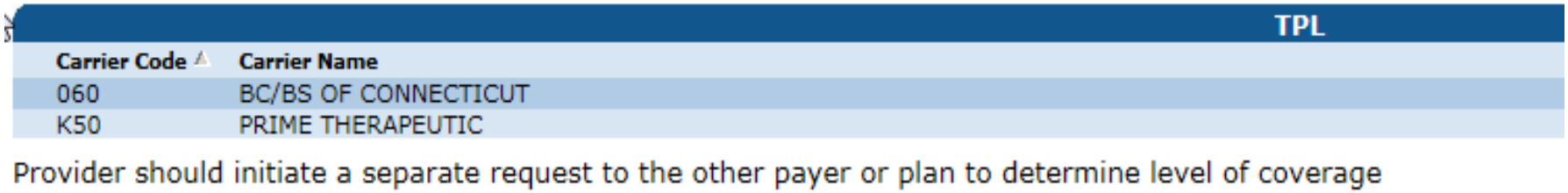
Professional Web Claim Submission



Professional Web Claim Submission

Medicaid is the Payer of last resort. The three digit Carrier Code of the Other Insurance (OI) is required to be submitted on the claim when OI is primary.

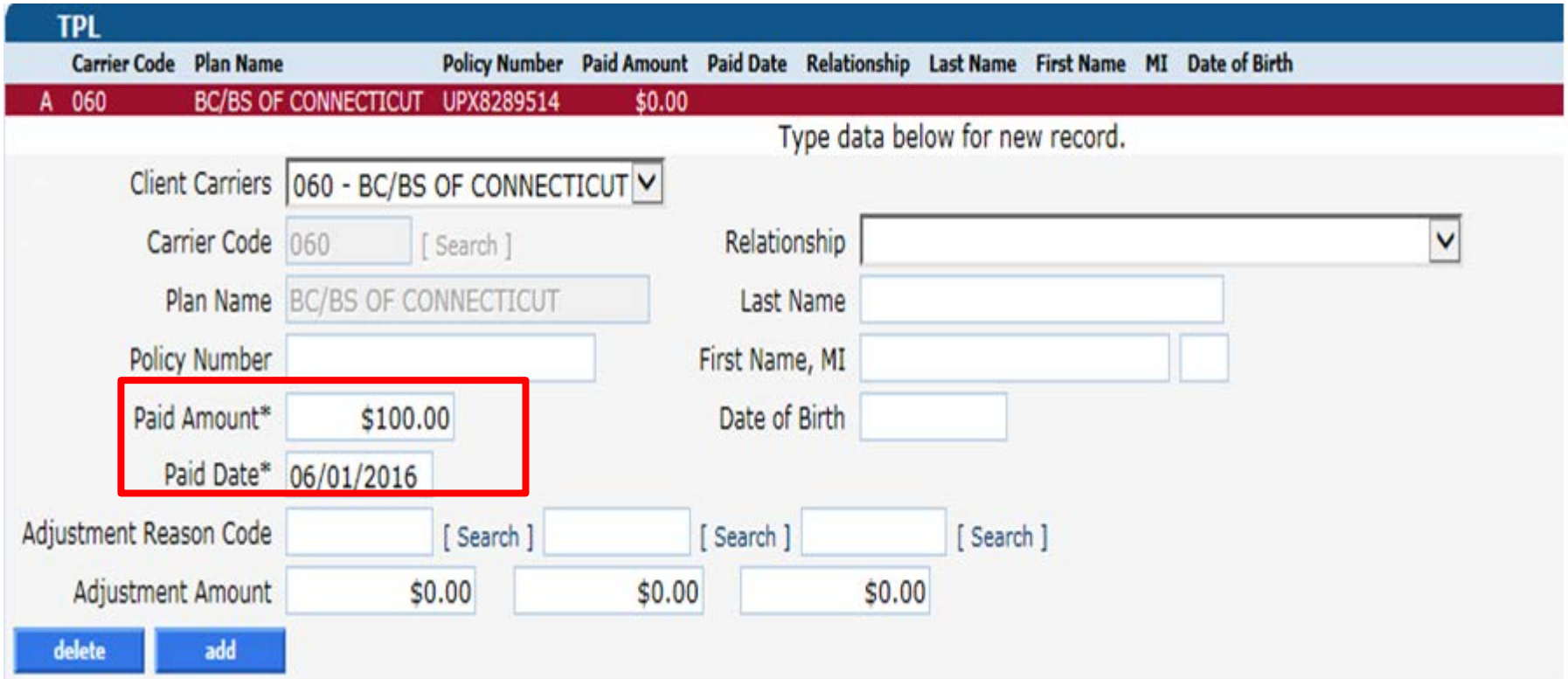
The three digit code can be found on the client eligibility verification screen under TPL (Third Party Liability) Information



It can also be found on the claim submission screen under the TPL panel in the **“Client Carriers”** field.

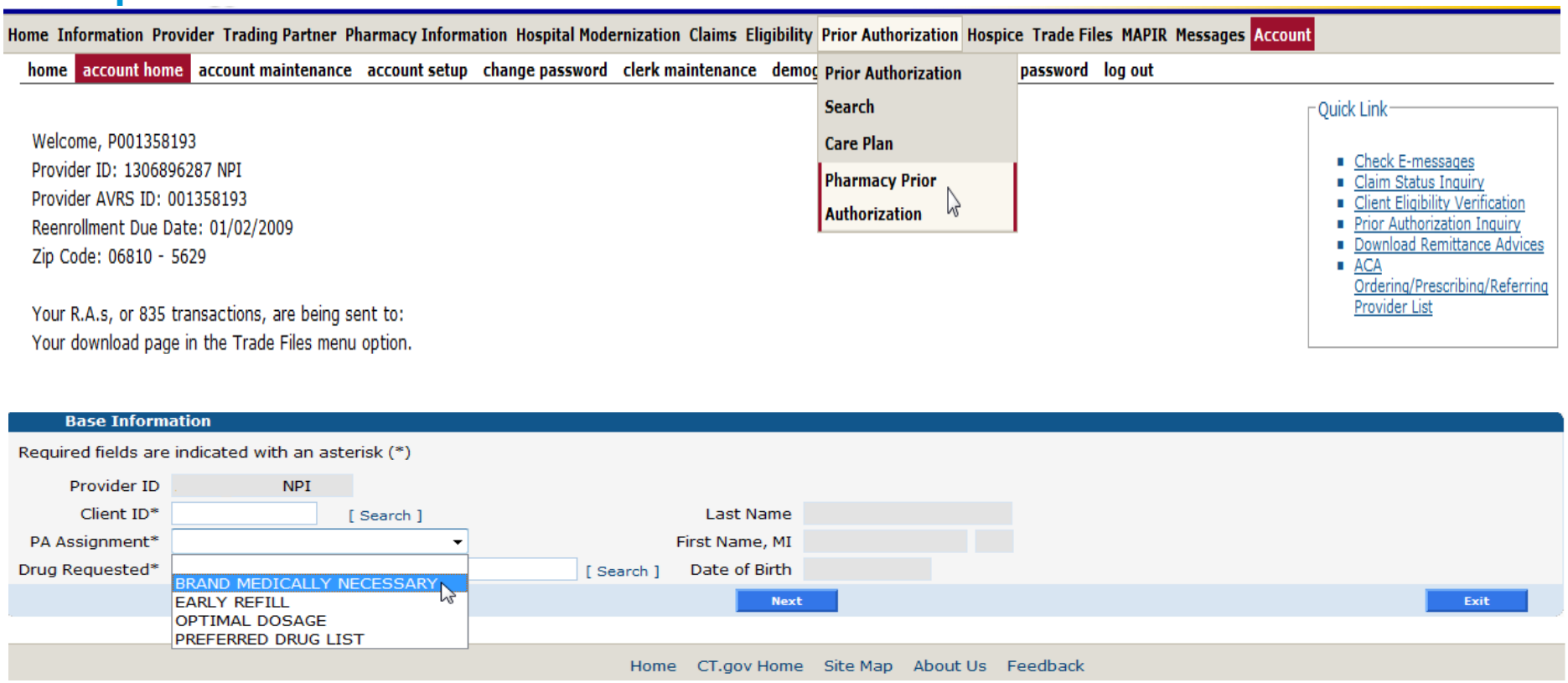
Professional Web Claim Submission

TPL payment of $100.00 from carrier code 060 with a paid date of 06/01/2016.



Pharmacy Web Prior Authorization

Enrolled prescribing providers can utilize the Pharmacy Web PA feature on the www.ctdssmap.com secure Web portal to Submit Pharmacy PA requests.



National Correct Coding Initiative (NCCI)

- To comply with federal legislation, the Department of Social Services (DSS) has adopted the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) standard payment edits designed to promote correct coding and control improper billing that could lead to inappropriate payments.

- **DSS has implemented the following NCCI edits:**
  - Medically Unlikely Edits (MUE) or units-of-service edits have been defined for each Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code which identifies the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g. claims for excision of more than one gallbladder).

National Correct Coding Initiative (NCCI)

- DSS will mirror Medicare's adoption of MUE edits and services exceeding the medically unlikely units will deny and post Explanation of Benefits (EOB) code 0770 "MUE Units Exceeded."
- Quarterly MUE updates are not published on the www.ctdssmap.com Web Site and providers are asked to refer to the CMS MUE tables by clicking on the link below to obtain published quarterly additions, deletions, and revisions:

  https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html

National Correct Coding Initiative (NCCI)

- Procedure code to procedure code (PTP) edits define 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.

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

A	B	C	D	E	F
Column1/Column 2 Edits					
1 Column 1	2 Column 2	3 * = In existence prior to 1996	4 Effective Date	5 Deletion Date *=no data	6 Modifier 0=not allowed 1=allowed 9=not applicable
99215	G0101		19980401	19980401	9

National Correct Coding Initiative (NCCI)

- Three Explanation of Benefits (EOB) codes inform providers if the procedure submitted on the claim fails the procedure code to procedure code edits.

- For some code pairs, modifiers may be used to bypass CCE which will allow column 1 and column 2 codes to be paid when performed on the same day for the same client.

Coding decisions for edits are based on conventions defined in the American Medical Association's (AMA's) "CPT Manual," national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Prior to the implementation of MUEs, the proposed edits are released for review and comment to the AMA, national medical/surgical societies, and other national health care organizations, including non-physician professional societies, hospital organizations, laboratory organizations, and durable medical equipment organizations. Similarly, proposed NCCI edits are released to various national health care organizations for review and comment prior to implementation.

National Correct Coding Initiative (NCCI)

EOB codes:

- 5924 – “Claim Denied, CCI Greater and Lesser Procedure are Not Covered on Same Date of Service”.
  - This edit will set if both the greater and the lesser procedure codes are submitted on the same claim.

- 5925 – “CCI Column 1 Code or Mutually Exclusive Code Was Billed on the Same Date as Previous Column 2 Code”.
  - This edit will set if the lesser procedure code has been paid and a claim with the greater procedure code is submitted for the same client for the same date of service.
    - The greater procedure will pay, but the lesser procedure will be recouped in the 2nd cycle of every month.

National Correct Coding Initiative (NCCI)

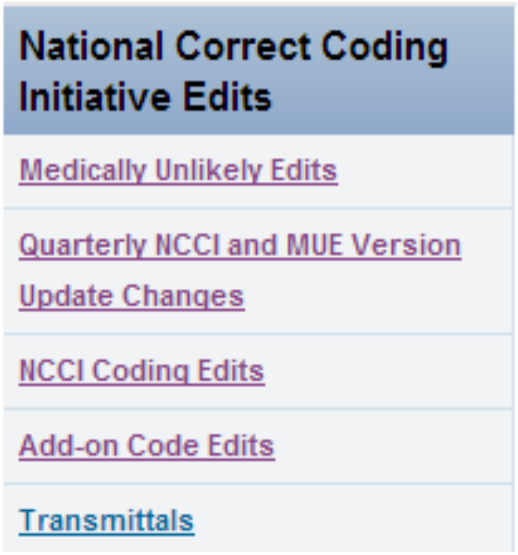
- 5926 – “CCI Column 2 Code Was Billed on the Same Date as Previous Column 1 or Mutually Exclusive Code”.
  - This edit will set if the greater code has been paid and a claim is submitted with the lesser code for the same client for the same date of service.

National Correct Coding Initiative (NCCI)

- **The list of modifiers allowed by Medicaid is identical to the list of modifiers allowed by Medicare.**
  - The Chapter 8 Physician Provider Manual has a detailed list of modifiers that can be used. This information can be accessed from our Web site www.ctdssmap.com. From the Home page, click on "Information", then "Publications", scroll down the page to Provider Manuals section, select "Physician" from the drop down menu for Chapter 8 and click "View Chapter 8".
  - Provider Bulletins addressing NCCI can be accessed from our Web site www.ctdssmap.com. From the Home page, click on "Information", then "Publications", and then enter the appropriate year and bulletin number under Bulletin Search.

National Correct Coding Initiative (NCCI)

- **Visit the CMS Web site http://www.cms.gov/NationalCorrectCodInitED/ for:**
  - Instructions on how to use NCCI
  - How to locate the NCCI Tables Manual
  - How to look up procedure code to procedure code edits
  - Use of bypass modifiers



Claim Resolution Guide

Provider Manual Chapter 12 – Claim Resolution Guide

- This guide lists commonly posted Explanation of Benefit (EOB) codes and provides a brief explanation of the reason why claims were either suspended or denied.
- This guide provides a detailed description of the cause of each EOB and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition.
- This guide also provides tips by identifying where providers can go to find additional information to assist with correcting their claims.

Example of an EOB:

EOB

View ◉ All ○ Current ○ Historical

Detail Number	EOB Code	EOB Description	Financial Payer	Benefit Plan	Status	Adjustment Amount	Adjustment Units	Origin
0	1912	BILLING PROVIDER'S TAXONOMY IS MISSING			Current	$130.00	0.000	System Generated
1	9996	REFER TO HEADER EOB			Current	$130.00	0.000	System Generated

Provider Audits

In accordance with subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes, audit protocols have been published on the Department of Social Services' Web site. An introduction to audit protocols and an overview of the audit process can be found at: http://www.ct.gov/dss/auditprotocols. Additional resources can be found in Bulletin PB17-29.

Links to audit protocols organized by provider type are located on the lower section of this Web page.

Alcohol and drug abuse centers audit protocols

Dental audit protocols

Homecare audit protocols

Home health audit protocols

Medical equipment audit protocols

Outpatient hospital audit protocols

Pharmacy audit protocols

Physicians audit protocols

Provider Audits

Introduction to Audit Protocols

These audit protocols are being published on the Department of Social Services' (the "Department") Internet website in accordance with subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes. The purpose of the protocols is to assist the medical provider community in developing programs to improve compliance with Medicaid requirements under state and federal law. Audit protocols are intended solely as guidance in this effort. As provided in subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes, these audit protocols "may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by any person, including a corporation," and do not constitute rulemaking by the Department. Nothing in the audit protocols alters any statutory or regulatory requirements. **In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.**

A Medicaid provider's legal obligations are governed by applicable federal and state law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law.

Audit protocols are applied to a specific provider or category of service in the course of an audit and involve the Department's application of articulated Medicaid agency policy and the exercise of agency discretion. The Department, consistent with state and federal law, may pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program.

The Department will amend its audit protocols as necessary. Reasons for amending protocols include, but are not limited to, responding to court or administrative decisions, directives from the Centers for Medicare and Medicaid Services or statutory or regulatory changes.

Provider Fee Schedules

All professional services will be reimbursed based on the physician fee schedule.

The current physician fee schedules can be accessed and downloaded from Connecticut Medical Assistance Web site, www.ctdssmap.com. From the Home page, go to "Provider", then to "Provider Fee Schedule Download", you must read and accept the End User License Agreement prior to downloading the fee schedule and click "I Accept" and then go to the appropriate "Physician" fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open".

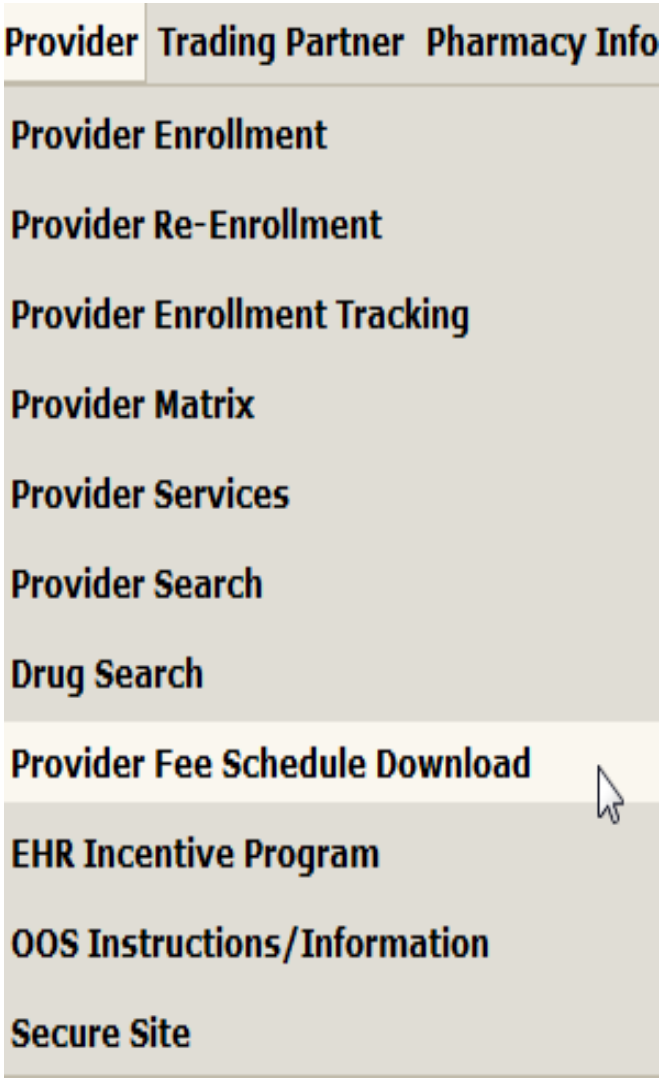
Services rendered by an APRN or physician assistant (PA) will be reimbursed at 90% of the established physician fee; or 90% of the obstetrical or pediatric fee when all of the applicable criteria are met.

Provider Fee Schedules

CMAP *fee schedules* are available for download from the Web site.

- Select *Provider* *Fee Schedule Download* from the *Provider* drop-down menu

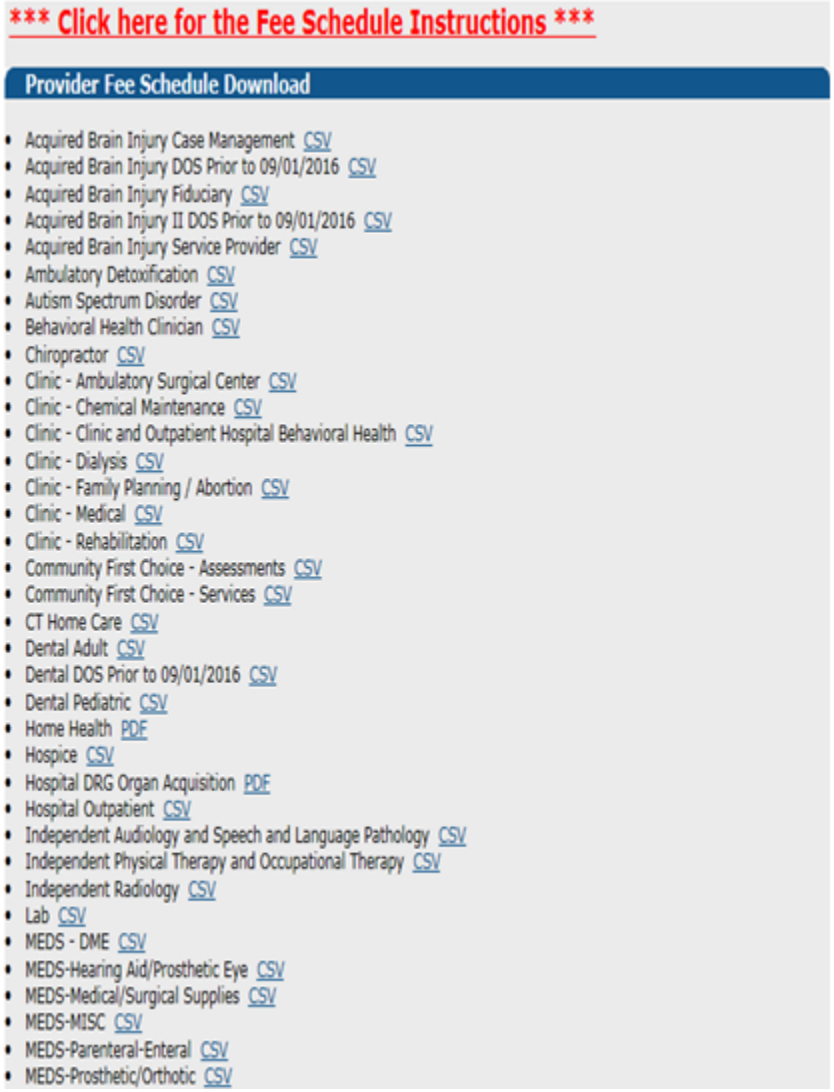
- You must read and accept the *End User License Agreement* prior to downloading the fee schedule; click *I Accept*



Provider Fee Schedules

- Provider Fee Schedules are listed by provider type and specialty.

- Click the corresponding link to download the appropriate fee schedule. If it is a CSV link, you will be required to hold down the “ctrl” key.



Provider Fee Schedules

Example of the Physician Surgical fee schedule:

	Physician Surgical							
	Rate type = PED; pediatric services; or OBS; obstetrical services; indicates a							
	_____unique rate for services for qualified clients and claim data. You may							
	_____disregard any other rate type.							
Procedure Code	Proc description	Mod1	Rate Type	Max Fee	Effective Date	End Date	PA	Surgery
37192	Redo endovas vena cava filtr		FTS	228.37	10/1/2014	12/31/2299		
37192	Redo endovas vena cava filtr		SUR	1134.5	1/1/2012	12/31/2299		
37193	Rem endovas vena cava filter		FTS	228.15	10/1/2014	12/31/2299		
37193	Rem endovas vena cava filter		SUR	1082.36	1/1/2012	12/31/2299		
37195	Thrombolytic therapy stroke		SUR	195.86	1/1/2008	12/31/2299		#
37197	Remove intrvas foreign body		FTS	186.68	10/1/2014	12/31/2299		
37197	Remove intrvas foreign body		SUR	788.05	1/1/2013	12/31/2299		

Rate Types

SUR – Surgical Rate

FTS – Facility Surgical Rate (For POS 19, 21-25, 31 or 32)

Provider Fee Schedules

Example of the Physician Office and Outpatient Services fee schedule:

Procedure	Proc description	Mod1	Mod1 des	Rate Type	Max Fee	Effective Date	End Date	PA
93010	Electrocardiogram report			DEF	5.12	1/1/2008	12/31/2299	
95810	Polysom 6/> yrs 4/> param	26		DEF	103.59	9/7/2015	12/31/2299	
95810	Polysom 6/> yrs 4/> param	26		DEF	265.53	8/18/2010	9/6/2015	
99283	Emergency dept visit			MPH	36.78	1/1/2012	12/31/2299	
99291	Critical care first hour			DEF	159.51	1/1/2008	12/31/2299	
99291	Critical care first hour			FTD	127.59	1/1/2015	12/31/2299	

Rate Types

DEF – Default Rate

MPH – Melded Physician Rate

FTD – Facility Default Rate (For POS 19, 21-25, 31 or 32)

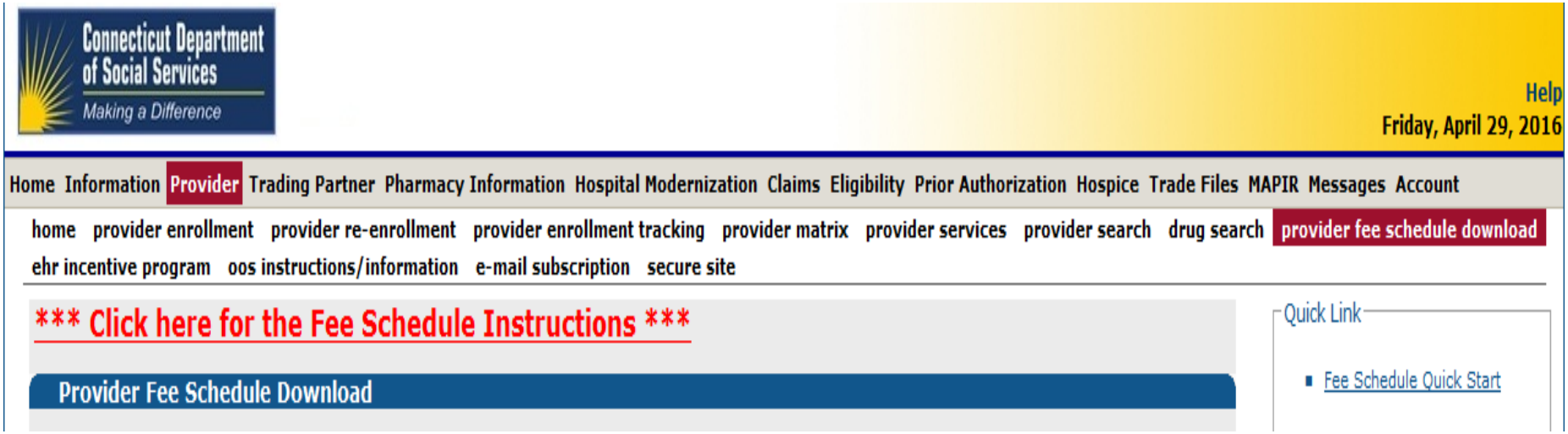
Fee Schedules (Footer Section)

The footer is a great source of additional information:

MP in Max Fee column designates Manually Priced
Psychiatry Specialty Physician/Groups or Advance Practice Nurse/Groups (Type/
_____Specialty 09/106; 09/339; 31/339; 31/639; 70/106; 70/339; 72/339; 72/639) for
_____coverage groups BHP A; BHP B; CHOAK; and FFS the following codes always require
_____PA: 90791; 90792; 90832; 90834; 90837; 90846; 90847; 90849; 90853; 90865;
_____90876; 90870; 90875; 90880; 90887; 96101; 96118; 99201-99215; 99241- 99245;
_____99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99318; 99324;
_____ 99325; 99326; 99327; 99328; 99334; 99335; 99336; 99337; 99339; 99340; and
_____M0064. To obtain PA contact CT BHP at 1-877-552-8247
To obtain PA for ICD-9-CM Diagnosis Codes 291-316 or for ICD-10-CM Diagnosis Codes
_____in the Fee Schedule Instructions Table 11 please contact CT BHP at
_____1-877-552-8247
PA required for ALL rehabilitation services beyond initial evaluation - HUSKY B and
_____Charter Oak (97010-97039; 97110-97150; 97530-97537; 97542-97546;
_____and 92507-92508)
87800; 88302; 88304; 88305; 88307; 90649; 90650; 90651; 96372; 99070; 99144; 99145;
_____99201-99205; 99211-99215; 99384-99386; 99394-99396; A4261; A4264;
_____A4266; J0696; J1050; J7297; J7298; J7300; J7301; J7302 (for dates of service
_____through 12/31/2015); J7303; J7304; J7306; and J7307
_____S4993; S5000; S5001 only codes covered for Family Planning Service Only clients
HUSKY B does not cover the following codes: 90880; 90901; 90911; 93784
_____93786; 93788; 93790; 97810-97814; 99450; 99455; 99456; A4264

Provider Fee Schedules

The Fee Schedule Instructions link can be found above the Provider Fee Schedules



HUSKY Health Primary Care Increased Payments Policy

As mandated under Section 1202 of the Affordable Care Act (ACA), Medicaid increased its payments to equal the 2013 and 2014 Medicare fee for certain primary care codes when billed by an eligible primary care provider, who has submitted a valid attestation to the Department of Social Services. In order to continue increased primary care payments for dates of service beyond December 31, 2014, the Connecticut General Assembly appropriated funding within the Medicaid budget. Effective January 1, 2015 the primary rate increase payments are being made under the **HUSKY Health Primary Care Increased Payment Policy** and are contingent on funding appropriated annually by the General Assembly.

Providers must be enrolled with CMAP and self attest to one or more of the following specialties:

- **Pediatric medicine**
- **Family Medicine**
- **Internal Medicine**
- **Subspecialists within one or more of the specialties listed above**

Please refer to PB 14-75, PB 15-44, and PB 17-44 for additional information as well as an IM published on the ctdssmap.com Web site.

Person-Centered Medical Home (PCMH)

The Department of Social Services introduced an initiative in 2012 for practices and clinics that demonstrates an innovative model of care focusing on the person rather than the medical condition.

Program Participation - To be eligible to apply and qualify for PCMH status, a practice must be enrolled in the CMAP under one of the following designations, Independent physician group, or solo practice; Hospital outpatient clinic.

Program Payment – Physician practices and Hospital outpatient clinics are eligible for higher level reimbursement for primary care services and performance-based payments.

Please visit www.HUSKYHealth.com for additional information.

Provider Bulletins

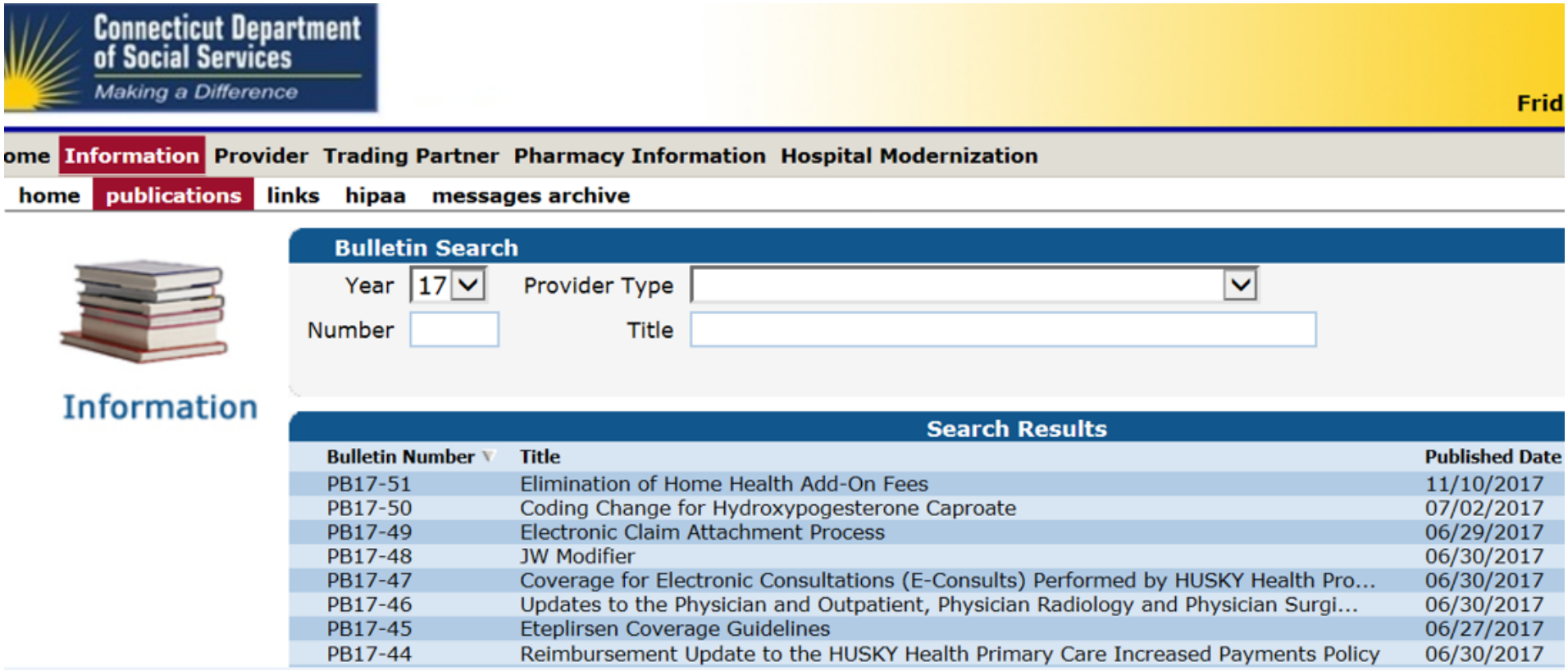
Provider Bulletins

- Access the Publications page by selecting Publications from either the Information box on the left hand side of the home page (www.ctdssmap.com) or from the Information drop-down menu.

- 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.
  - When searching by provider title, you can search by any word as long as that word is in the title of the bulletin.

Provider Bulletins

Provider Bulletins – Searching by Year and Type



Re-enrollment

Re-enrollment Period:

- Most provider types are required to re-enroll every five years
- Providers will receive a letter when they are due for re-enrollment six (6) months prior to the end of their current contract
- If the provider has not successfully re-enrolled three (3) months prior to the end of their current contract, another letter will be sent
- Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from the Connecticut Medical Assistance Program (CMAP)
- The following are some of the providers that are required to re-enroll every two years:
  - Clinics (Except Enhanced Care) – DME/MEDS - Drug and Alcohol Abuse Centers
- The complete list of enrollment periods can be found in Chapter 3 of the Provider Manual
- Re-enrollment via the Enrollment/Re-enrollment Wizard on the CMAP Web site, www.ctdssmap.com, is required

Organization and individual providers with Secure Web portal access can view their re-enrollment due date on the Home page of their Secure Web portal once logged in!

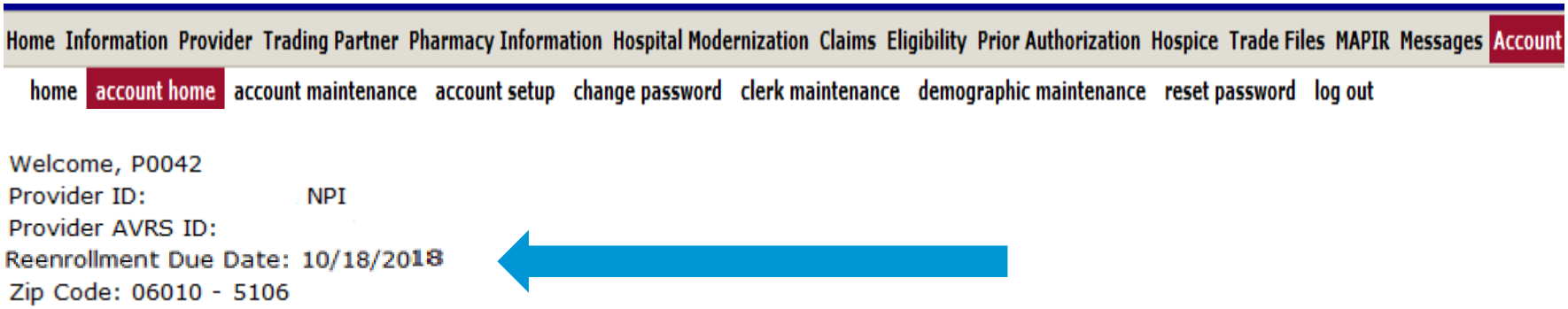
Re-enrollment

Re-enrollment Due Dates:

Providers with Secure Web portal access can view their re-enrollment due date once logged in!

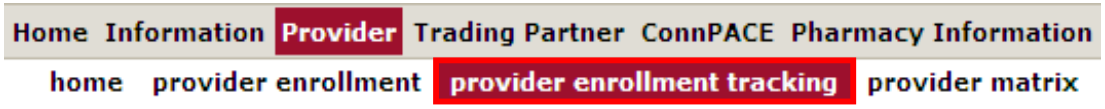
- Individual providers can view their re-enrollment due date on the Home page
- Organization providers can view their re-enrollment due date, as well as the re-enrollment due date of their members by accessing the “Maintain Organization Members” panel

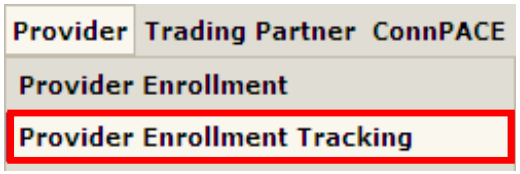
- This enhancement allows individual providers and organizations to better track their re-enrollment due dates prior to receiving their notice to re-enroll



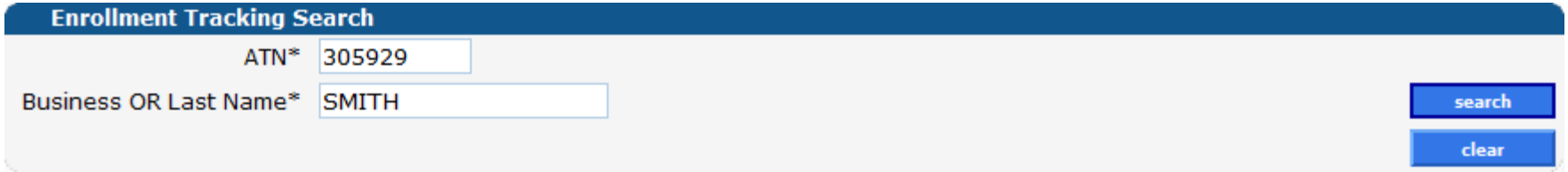
Re-enrollment

To check the status of an enrollment / re-enrollment application, select *Provider Enrollment Tracking* from either the *Provider* submenu or the *Provider* drop-down menu

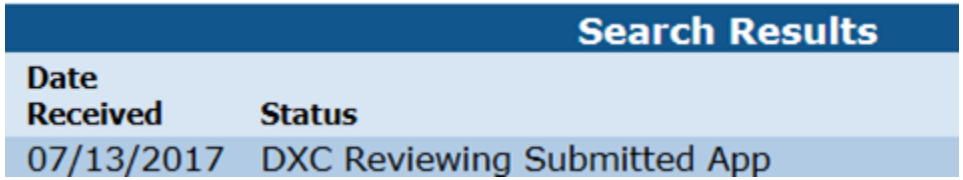




Enter your *ATN* and *Business OR Last Name* and click *search*



- In this example DXC Technology is reviewing the application that was submitted by Jonathan Q. Smith on July 13, 2017.



Re-enrollment

Performing Providers:

- Billing groups need to associate their **performing providers** to the group since performing providers are now enrolled / re-enrolled independent of the groups they belong to.

- The performer would re-enroll according to their re-enrollment due date which may be different from the group.

- The re-enrollment letter will only be sent to one address if the performing provider belongs to more than one group.

- Organizations/Groups can view the re-enrollment due dates of their members by accessing the “Maintain Organization Members” from the “Demographic Maintenance panel”.

- This enhancement will allow organizations/groups to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

Announcements

The Department of Social Services, has mandated that as of October 1, 2016 - paper claims are no longer be accepted for reimbursement.

Paper claims submitted to DXC Technology on or after October 1, 2016 will be destroyed.

Several on-line resources are available to providers to assist with this transition:

Provider Manuals
Chapter 5 – Claim Submission Information
Chapter 8 – Provider Specific Claim Submission Instructions
Chapter 11 – Other Insurance and Medicare Billing Guides

Other Web Resources
Internet Claim Submission FAQ

* Excluded from this mandate are provider claims that are submitted to DXC Technology for special handling, such as timely filing overrides.

Announcements
Face-to-Face Requirements – Home Health

Effective for home health services (new or initial orders) ordered on or after July 1, 2017, a face-to-face visit and physician certification will be required for home health services that are paid under the Medicaid State Plan for HUSKY Health members (HUSKY A, B, C, and D). All home health services paid under the Medicaid State Plan as well as those provided to Medicaid waiver members must also comply with these requirements.

Full documentation on these requirements can be found in Provider Bulletin PB17-02 New Face-to-Face Requirements for Initial Orders of Home Health Services on the ctdssmap.com website.

- **Federal Regulations mandate the face-to-face encounter MUST:**
  - be related to the primary reason that the HUSKY Health member requires home health services;
  - occur between the HUSKY Health member and an enrolled physician; or between the HUSKY Health member and an enrolled non-physician practitioner* (NPP), defined as an APRN, PA, or CNM working in collaboration with an enrolled physician; and
  - occur within a period that is no more than 90 days before or 30 days after, the start for all initial orders for home health services.

(*Note: although NPPs are allowed practitioners to perform the face-to-face encounter, per federal regulations, only a physician can order home health services)

Announcements
Face-to-Face Requirements – Home Health (cont.)

Home Health Face-to-Face Encounter Documentation Requirements

- The ordering physician must maintain documentation, either in hard copy or electronic form, in the HUSKY Health member's medical record and also provide documentation to the home health agency (HHA) substantiating that the face-to-face requirements have been met.
- The HHA must ensure that it has received this documentation for each HUSKY Health member for whom a face- to-face visit is required.
- The HHA must also maintain the documentation, in hard copy or electronic form, in the HUSKY Health member's medical records at the home health agency.

Documentation must, at minimum, include ALL of the following:

- In the case where the face-to-face was performed by an authorized practitioner other than the physician ordering the home health service, the clinical findings of the face-to-face encounter, substantiating the need for home health services;
- The primary reason for which home health services are required;
- The date of the face-to-face encounter;
- The name, either hard copy or digital signature, and credentials of the practitioner who conducted the face-to- face encounter; and
- the dated signature of the enrolled physician who has prescribed the home health services if the face-to-face encounter was performed by a NPP

Announcements
Face-to-Face Requirements – DME

Effective for certain durable medical equipment (DME) ordered on or after July 1, 2017, a face-to-face visit with an enrolled physician, physician assistant or advanced practice registered nurse (APRN) in addition to the prescription order is required.

Full documentation on these requirements can be found in Provider Bulletin PB17-19 New Face-to-Face Requirements for Certain Durable Medical Equipment (DME) on the ctdssmap.com website.

Federal Regulations mandate the face-to-face encounter MUST:

- be related to the primary reason the HUSKY Health member requires the DME;
- occur between the HUSKY Health member and a Connecticut Medical Assistance Program (CMAP), enrolled physician, physician assistant, or APRN;
- take place on or before the date of the prescription/order;
- not be older than 6 months prior to the date on the prescription/order; and
- be on or before the date of delivery.

The list of DME that requires the face-to-face encounter can be found by accessing the following Web site link:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf

Announcements
Face-to-Face Requirements – DME (cont.)

DME Face-to-Face Encounter Documentation Requirements

- **The ordering physician, physician assistant, or APRN must maintain documentation in the HUSKY Health members' medical record and also provide documentation to the DME provider substantiating that the face-to-face requirements have been met.**
- **The DME provider must ensure that it has received this documentation for each HUSKY Health member for whom it is required.**
- **The DME provider must also maintain the documentation in the HUSKY Health member's record or files at their own location. The documentation can either be in hard copy and/or electronic format, but it must be maintained in the HUSKY Health member's medical record as well as submitted and maintained by the DME provider.**

Documentation must, at minimum, include ALL of the following:

- **the clinical findings of the face-to-face encounter substantiating the need for the DME;**
- **the primary reason that the DME is required;**
- **the name (including either hard copy or digital signature) and credentials of the physician, physician assistant, or APRN who conducted the face-to-face encounter; and**
- **the date of the face-to-face encounter.**

For the DME items that require PA, if the face-to-face encounter documentation does not include information supporting that the member was evaluated and/or treated for a condition that supports the item(s) of DME ordered, the PA request will be denied.

Announcements
Face-to-Face Requirements – DME (cont.)

DME Prescription Requirements:

- The physician, physician assistant, or APRN who conducts the face-to-face encounter does not have to be the same physician, physician assistant, or APRN who signs the prescription. However, both practitioners must be enrolled with the Connecticut Medical Assistance Program.
- Prescription/order must be produced by a qualifying prescriber, who must verify that a face-to-face encounter visit took place within 6 months prior to the date of the prescription/order and that the clinical findings support the need for the DME item that he or she has ordered.
- Prescriber must also have documentation of the qualifying face-to-face encounter that was conducted.

All DME prescriptions/orders shall include the following:

- Member's name, address and date of birth;
- Diagnosis for which the DME is required;
- Detailed description of the DME items(s), including quantities and any special option or add-ons;
- Length of need for the DME use;
- Prescribing practitioner's name and address; and
- Prescribing practitioner's signature and signature date.

Additionally, the NPI of the prescribing practitioner is required on the prescription.

Announcements
Face-to-Face Requirements – DME (cont.)

A New Face-to-Face Encounter is required for the following:

• for all initial orders for the purchase or rental of specified DME items and/or related supplies;

• when a member has not had a face-to-face encounter within 6 months of an initial order for the involved DME items; and

• when there is a change in DME provider

A new face-to-face encounter is not required for repairs or service of DME equipment. Note, however, as outlined in PB2009-19, that a new prescription/order is required.

Resources

- **Connecticut Medical Assistance Program Web site**
- www.ctdssmap.com
- **Information > Publications > Claims processing information**
  - Internet Claims Submission FAQ
- **Information > Publications > Provider Manuals**
  - Chapter 8 Provider Specific Claim Submission Instructions
  - Chapter 10 Web Portal/AVRS
  - Chapter 11 Other Insurance and Medicare Billing Guides
  - Chapter 12 Claim Resolution Guide

Contacts

DXC Technology Provider Assistance Center (PAC)

1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays

CTDSSMAP - ProviderEmail@dxc.com

DXC Technology Pharmacy Prior Authorization Assistance Center (PPAAC)

1-866-409-8386 – In the office Monday thru Friday, 7:00 AM – 9:00 PM (EST), and Saturday, 9:00 AM – 4:00 PM (EST), on-call service available outside of office hours.

DXC Technology Electronic Data Interchange (EDI) Help Desk

1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

CHNCT Provider Relations (prior authorizations)

1-800-440-5071 – Monday through Friday, 9 a.m. to 7 p.m. (EST)

Beacon Health Options

1-877-552-8247– Monday through Friday, 9 a.m. to 7 p.m. (EST)

www.ct.gov/husky

www.CTDSSMAP.com

Time for Questions

Questions & Answers