Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2009-28**
www.ctdssmap.com **August 2009**

TO: All Providers

RE: 1. New Provider Bulletin Format
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1. New Bulletin Format

The Department of Social Services (DSS) and EDS are working towards reducing publication and mailing costs. The format has changed and multiple topics may be included in a single publication. Please review all bulletins and policy transmittals carefully as they provide important program and claim processing information.

2. Claim Status Inquiry Instructions

DSS and EDS are committed to providing a quick and accurate response to claim status inquiries using the most efficient methods available. On June 24, 2008, claims status inquiry functionality was made available on the secure Web Portal. **Beginning September 8, 2009**, all claim status inquiries must be verified via the secure Web Portal, the Automated Voice Response System (AVRS), EDS' Provider Electronic Solutions Software (PES) or by a direct ASC X12N 276/277 Health Care Claim Status Request transaction. By using these self service tools, providers will receive a timely response to claim status inquiries while reducing call wait times when calling the Provider Assistance Center.

How do I utilize the secure Web Portal to verify claim status?

- Log onto the secure Web Portal at www.ctdssmap.com
- Select Secure Site under Provider
- Enter Web user ID and password
- Click on Claims
- If you do not have access to Claims, please contact your primary account holder to provide you with access to the Claims tab.
- Select Claim Inquiry
- Enter the Client ID number in the Client ID field and the from and through dates of service in the FDOS and TDOS fields. (Note: The FDOS and TDOS span can not exceed 93 days)
- The Web will return all claims that match the criteria entered that are present in interChange.
- Select a claim by clicking on the specific row. The claim status panel is located at the bottom of the page.

How do I utilize the AVRS to verify claim status?

- Call the Provider Assistance Center at 1-800-842-8440 (in state) or local to Farmington, CT or Out-of-state callers at 1-860-269-2028.
- Select option 4 (Self Service Option)
- Enter AVRS ID and PIN
- Select option 3 (Claim Status)
- Enter the client number and the from and through dates of service
- AVRS will return the status of the most recently processed claim that matches the criteria entered.
- If you have a question on the claim you inquired upon, you can select option 0 to be transferred to a Call Center Representative.

How do I use Provider Electronic Solutions Software to Prepare a Claim Status Inquiry?

This process must be completed in two steps. The first step is to submit your request for claim status (276 transaction) and the second step is to retrieve the response to the claim status request (277 transaction).

Step 1

- Select the CLM icon or Select Forms ◊ 276 Claim Status Request.
- Complete Tab 1 & 2 for each inquiry. Click on Save button. If more than one inquiry is to be sent, click on Add button and repeat steps.
- To transmit 276 Claim Status file:
  - Select Communication
  - Submission
  - Files to Send
  - 276 Claim Status Request
  - Submit
  - Close *Please note that there might be a slight delay in the retrieval of the 277 transaction.

Step 2

- To retrieve a 277 Claim Status Response using Provider Electronic Solution software:
  - Select Communication
  - Submission
  - Files to Receive
  - 277 Claim Status Response
  - Submit
- To view the 277 Claim Status Response:
  - Select Communication
  - View Batch Response

What if I still have a question regarding a claim after checking the claim status on the Web Portal, AVRS or PES?
Please contact the Provider Assistance Center at 1-800-842-8440 (in state) or local to Farmington, CT or Out-of-state callers at 1-860-269-2028 with an Internal Control Number obtained from your initial inquiry using one of the claim submission inquiry methods referenced in this bulletin.

3. Provider Participation Status for Non-Actively Billing Providers

In order for providers to continue to participate in the Connecticut Medical Assistance Program, providers must be actively submitting claims. It is DSS' policy to disenroll providers who have not had any claim activity for the past twelve (12) months. DSS is re-instituting a process to disenroll providers who meet this criteria. If providers are disenrolled from the program for this reason, a letter will be sent notifying the providers that this action has been taken. Once a provider has been disenrolled, a new Provider Enrollment Application to reinstate the provider's participation in the Connecticut Medical Assistance Program must be completed. For the provider's convenience, enrollment is available on-line at www.ctdssmap.com, by selecting Provider, and then Provider Enrollment.

4. PERM Audit Requests

The Improper Payments Information Act of 2002 directs Federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review its programs that are susceptible to significant erroneous payments and report the improper payment estimates to Congress. OMB identified the Medicaid and the State Children's Health Insurance Program (SCHIP) as programs at risk for significant erroneous payments.

The Centers for Medicare and Medicaid Services (CMS) will measure the accuracy of Medicaid and SCHIP payments made by States for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. Under the PERM program, CMS uses 2 national contractors to measure improper payments in Medicaid and SCHIP. Your interactions in this process will be primarily with our documentation/database contractor (DDC), Livanta, who will collect medical policies from the State and medical records from you either in hardcopy or electronic format.

Medical records are needed to support required medical reviews for PERM so that our review contractor can review the fee-for-service Medicaid and SCHIP claims to determine if the claims were correctly paid. If a claim, in which your provider number was identified on the claim to receive reimbursement, is selected in a sample for a service that you rendered to either a Medicaid or SCHIP recipient, the DDC will contact you for a copy of the required medical records to support the medical review of the claim. For reviews that require extra information, the DDC will contact you for additional documentation. You will then have 15 days to respond to the request.

Understandably, you are concerned with maintaining the privacy of patient information. However, you are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for rendering services. The furnishing of information includes medical records. As for SCHIP, section 2107(b)(1) of the Act requires an SCHIP State plan to provide assurances to the Secretary that the State will collect and provide to the Secretary any information required to enable the Secretary to monitor program administration and compliance and to evaluate and compare the effectiveness of States' SCHIP plans. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes **is permissible** by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

In order to obtain medical records for a claim sampled for review, the DDC will contact you to verify the correct name and address information and to determine how you want to receive the request (i.e., facsimile or U.S. mail) for medical records. Once you receive the request for medical records, you must submit the information electronically or in hard copy within 60 days. Please note that it will be the responsibility of the provider who is identified on the claim to receive payment, to ensure that any and all supporting medical records, from any and all provider(s) who rendered a service for which the claim payment under review was requested, is submitted in a timely manner. During this 60 day timeframe, the DDC will follow up to ensure that you submit the documentation before the timeframe has expired, and your State officials may contact you to assist in identifying the required documentation for submission.

It is important that you cooperate with submitting all requested documentations in a timely manner because no response or insufficient documentation will count against the State as an error. Past studies have shown

that the largest cause of error in medical reviews is no documentation or insufficient documentation. As such, it is important that information be sent in a timely and complete manner. If you have any questions about this matter, please contact your State PERM Contact:

John McCormick at 860-424-5920 or
John.McCormick@ct.gov

Thank you for your support of the PERM program.

5. Extended System Downtime

EDS will be implementing hardware and software upgrades on Sunday, August 23 and all systems will be unavailable from 12:00 midnight to 8:00 a.m.