interChange Provider Important Message

Hospital Monthly Important Message Updated as of 04/11/2018

*all red text is new for 04/11/2018

The following documents were recently updated:

CMAP Addendum B

Connecticut Medical Assistance Program's (CMAP's) Addendum B effective for dates of service January 1, 2018 was updated on February 28, 2018.

Any procedure code additions or changes with an effective date of January 1, 2018 were updated in the system on February 28, 2018. Procedure codes being deleted with an end date of December 31, 2017 were also updated in the system on February 28, 2018.

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system with a January 1, 2018 effective date on January 10, 2018. Any claims for procedures with a status indicator of G or K for dates of service January 1, 2018 that were processed between January 1, 2018 and January 10, 2018 were reprocessed and appeared on your February 27, 2018 Remittance Advice (RA).

Provider Manual Chapter 8 Updated

Updates included: Added procedure code 97763 under Physical and Occupational Therapy Revenue Center Codes (RCCs) and procedure codes 97127 and G0515 under Physical, Occupational and Speech Therapy RCCs.

Provider Manual Chapter 10 Updated

On February 26, 2018 DXC updated the Automated Voice Response System (AVRS) for Third Party Liability (TPL) and Medicare to no longer provide policy information. For TPL we only provide carrier code and carrier name. For Medicare we only provide the coverage information.

Provider Manual Chapter 12 Updated

Updates included: Added claim cause and resolution for the following EOB codes:

0326 "APC – Service Submitted for Denial"
0878 "Allowed Amount is Zero Manual Priced Outpatient APC, Provider Fee Schedule, if Not Outpt Contact PAC"
7501 "Denied MUE Detail After Review"
7502 "Denied MUE Detail Never Received or Needs Additional Information for Further Review"

Outstanding Questions

Outpatient Therapies Claims

- 4/1/2018 - The hospitals have requested DXC Technology to review outpatient therapies claims not reimbursing up to the flat rate due to the first detail billing less than the contract rate and the second detail denying as a duplicate. DXC Technology has reviewed the outpatient claims and is working on system updates.

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DXC Technology has identified an outpatient therapy issue were the therapies claims were paid over the flat rate due to duplicate payments for one date of service.

Once the system has been updated DXC Technology will reprocess and adjust the claims to pay at the flat rate.

Provider Bulletin 2018-16 Tisagenlecleucel (Kymriah™) and Voretigene Neparvovec-rzyl (Luxturna™) Coverage Guidelines

Effective April 1, 2018, new coverage guidelines will be used in conjunction with the Department of Social Services' (DSS) definition of medical necessity to render determinations on prior authorization (PA) requests for coverage of tisagenlecleucel marketed as Kymriah™ and voretigene neparvovec-rzyl marketed as Luxturna™, for HUSKY A, HUSKY B, HUSKY C and HUSKY D members.

Prior Authorization Submission Process: Providers must fax the applicable completed PA form to CHNCT at (203) 265-3994.

KymriahTM PA requests should be submitted with procedure code Q2040 (tisagenlecleucel, up to 250 million CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion) and the applicable national drug code (NDC). LuxturnaTM PA requests should be submitted with procedure code C9399 (unclassified drugs or biologicals) and the applicable NDC.

Provider Bulletin 2018-10 - Updates to the Reimbursement Methodology for Physician-Administered Drugs, Immune Globulins, Vaccines and Toxoids

The only drugs administered in the outpatient hospital setting and billed under the Outpatient Prospective Payment System (OPPS) – Ambulatory Payment Classification (APC) reimbursement methodology that will be impacted by this update are the physician administered drugs, immune globulins, vaccines and toxoids that are listed as "FS" under the payment type column and points to the OFOUT fee schedule on the Connecticut Medical Assistance Program's (CMAP) Addendum B.

No changes are being made to the reimbursement to outpatient hospitals for physician administered drugs, immune globulins, vaccines and toxoids that are reimbursed under the OPPS – APC reimbursement methodology, have a status indicator of "G" or "K" and are listed as "APC-PR" under the payment type column.

Provider Bulletin 2018-06 - Billing Clients for Missed appointments - Reissue of PB15-05

In 2015, The Department of Social Services (DSS) issued Policy Transmittal 2015-03 (PB 2015-05) to address the topic of billing clients for missed appointments. DSS is issuing this provider bulletin to update the Transportation Broker contact information and to remind providers that federal and state policies prohibit charging Medicaid clients for broken, missed or cancelled appointments. DSS has seen an increase in client complaints about being asked to pay for missed appointments or to sign forms accepting liability for missed appointments. DSS has also received an increasing number of inquiries from providers, as they try to determine how Medicaid fits within the changing business practices related to charging for missed appointments. In addition, this policy is applicable when Medicaid is secondary to a commercial plan and/or Medicare.

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Reminders / Updates

Reduced/Discounted services

Currently reduced and discounted services are not payable and identified when billed with Modifier 52 "Reduced Services" and Modifier 74 "Procedure Discounted after Anesthesia" and will deny with EOB 0335 "APC – REDUCED/DISCONTINUED PROCEDURES ARE NOT PAYABLE." DSS has reviewed the hospital's request and at this time these services will continue to be not payable. The only time the Department will consider modifier 52 is when it is billed in connection to Intensive Outpatient Program (IOP) or Partial Hospitalization Program (PHP) services.

Scheduled Hospital Refresher Workshops:

Connecticut Hospital Association, 110 Barnes Road, Wallingford, CT
Monday April 23, 2018 9:00 AM – 12:00 PM

HPE MyRoom Virtual Classroom Training
Thursday April 26, 2018 1:00 PM – 4:00PM

The topics include:

- Prior Authorization
- Web Claim Submission / Adjustments
- CMAP Addendum B
- Outlier Payments
- APR DRG
- Timely Filing Guidelines
- Hospital Modernization Page
- Frequent Claim Denial

To register for these workshops, visit the www.ctdssmap.com Web site, go to the Hospital Modernization page and click on the Provider Training link in the quick link box. Under workshops, click on the Hospital Refresher Workshop Invitation. Click on the registration link for the workshop you wish to attend, and fill out the corresponding information.

Healthcare Common Procedure Coding System (HCPCS) unit updates

The units were updated on the following HCPC codes on March 7, 2018 effective for Dates of Service January 1, 2018 and forward.

J0565 increased to 113 units, J1428 increased to 341 units, J1627 increased to 100 units, J1726 increased to 25 units, J2326 increased to 120 units, J7210 increased to 22000 units, J9022 increased to 120 units, J9285 increased to 170 units and J3358 increased to 520 units.

Prior Authorization Requirements for Advanced Imaging Services Reminder in an Outpatient Hospital Setting

As a reminder, when certain radiology services are performed in an outpatient hospital setting, the ordering provider must request prior authorization (PA) using the corresponding Healthcare Common Procedure Coding System (HCPCS) "C" code instead of the Current Procedural Terminology (CPT) code. Hospitals should confirm that a valid, approved PA is on file for the appropriate "C" code prior to performing the service. Please reference Provider Bulletin 2016-70 – "Important Changes to the Radiology Benefit Management Program" for a list of CPT codes that have a corresponding "C" HCPCS code.

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Outpatient Hospitals must confirm that a valid, approved PA is on file for the appropriate "C" code. If the PA on file doesn't have a "C" code the outpatient claim will deny and the hospital would need to contact Community Health Network of CT (CHNCT) at 1-800-440-5071 for assistance.

Resident Enrollment Step by Step Instruction Guide

DXC Technology has posted a resident enrollment instruction guide on the www.ctdssmap.com Web site under important messages. The important message provides a step by step guide on completing an application for enrollment or re-enrollment as a resident in the Connecticut Medical Assistance Program (CMAP).

APC/DRG E-mail box ctxixhosppay@dxc.com

Reminder: ctxixhosppay@dxc.com e-mail address should only be used when the hospital has questions related to APC or DRG processing. Prior to emailing questions the hospitals should refer to provider manual chapter 12 claim resolution guide for brief explanations on why a claim detail or the entire claim denied.

The hospitals should be contacting the provider assistance center at 1-800-842-8440 for non APC or DRG questions. Examples of non APC or DRG questions are prior authorization, third party liability and eligibility questions**.**

Re-enrollment Reminder for Hospitals

The hospitals are reminded to take note of their re-enrollment due date with CMAP. Failure to complete and submit their re-enrollment application in enough time to allow for review by DSS by **the re-enrollment due date** will cause the hospital to be dis-enrolled on the re-enrollment due date and no claims after that date will be allowed until the re-enrollment is completed.

This will impact claims processing and the hospitals' ability to verify eligibility until the re-enrollment has been completed.

Organizations 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. The following hospitals have re-enrollment due dates coming up in the near future:

- St Francis Hospital Inpatient Psych – 04/20/2018
- St Francis Hospital Inpatient Acute Care - 04/22/2018
- St Francis Hospital Outpatient Hospital - 04/22/2018
- St Vincent's Medical Center Intermediate Duration Acute Psychiatric Care – 05/23/2018
- Hartford Hospital Outpatient Psych – 05/30/2018

CMAP Addendum B Timeline

2016 - Time-period: 7/1/16 to 12/31/16

CMAP Addendum B (July 2016 V17.2) was updated on September 28, 2016.

DXC Technology will be adjusting outpatient claims with procedure codes that had status indicator changes, other changes identified in the CMAP Addendum B September Changes document for dates of service July 1, 2016 to September 27, 2016 that were processed prior to September 28, 2016. Only 19 procedure codes had changes.

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CMAP Addendum B (October 2016 V17.3) was updated on November 30, 2016.

DXC Technology will be adjusting outpatient claims with procedure codes that had status indicator changes, other change indicated by an "X" and new procedure codes identified as "N" in the change field CMAP Addendum B October Changes document for dates of service October 1, 2016 to November 1, 2016 that were processed prior to November 30, 2016. Only 16 procedure codes had changes.

Payment rate changes for procedure codes assigned a status indicator "G" or "K" were updated and loaded into the system with an effective date of October 1, 2016 were loaded on November 15, 2016.

2017 - Time-period: 1/1/17 to 12/31/17

CMAP Addendum B (January 2017 V18.0) was updated on March 1, 2017

DXC Technology will be adjusting claims with APC weight changes, status indicator changes, other change indicated by an "X" and new procedure codes identified as "NEW" in the change field CMAP Addendum B January 2017 changes for dates of service January 1, 2017 to March 1, 2017 that were processed prior to March 1, 2017.

CMAP Addendum B (April 2017 V18.1) was updated on April 26, 2017.

Dates of Service April 1, 2017 to April 24, 2017 that was processed prior to April 26, 2017 changes for 17 procedure codes. DXC technology identified that no claims need to be adjusted due to not receiving any outpatient claims with procedure codes that were changed.

Payment rate changes for procedure codes assigned a status indicator "G" or "K" were updated and loaded into the system with an April 1, 2017 were loaded on April 3, 2017 and no claims were processed prior to the update.

CMAP Addendum B (July 2017 V18.2) was updated on July 26, 2017.

Dates of Service July 1, 2017 to July 25, 2017 that was processed prior to July 26, 2017 changes for 33 procedure codes. DXC technology identified that no claims need to be adjusted due to not receiving any outpatient claims with procedure codes that were changed.

Payment rate changes for procedure codes assigned a status indicator "G" or "K" were updated and loaded into the system with a July 1, 2017 effective date prior to July 1, 2017 no claims effected.

CMAP Addendum B (October 2017 V18.3) was updated on November 8, 2017.

Dates of Service October 1, 2017 to November 6, 2017 that was processed prior to November 8, 2017 changes to 17 procedure codes had changes. DXC technology identified that no claims need to be adjusted due to not receiving any outpatient claims with procedure codes that were changed.

Payment rate changes for procedure codes assigned a status indicator "G" or "K" were updated and loaded into the system with a October 1, 2017 effective date prior to October 1, 2017 no claims effected.

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2018
Time-period: 1/1/18 to 2/28/18

CMAP Addendum B (January 2017 V19.0) was updated on February 28, 2018.

DXC Technology will be adjusting claims with APC weight changes, status indicator changes, other change indicated by an "X" and new procedure codes identified as "NEW" in the change field on the CMAP Addendum B January 2018 changes for dates of service January 1, 2018 to February 28, 2018.

Payment rate changes for procedure codes assigned a status indicator "G" or "K" were updated and loaded into the system with an effective date of January 1, 2018 on January 10, 2018 and any claims that paid at the old rate were adjusted and reprocessed and appeared on the hospital's February 27, 2018 Remittance Advice (RA).

On the www.ctdssmap.com Web site under Hospital Outpatient Payment Methodology - Ambulatory Payment Classification (APC) click on CMAP Addendum B Changes and Historical Version and that will break out all the changes and updates for each CMAP Addendum B version.