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Hospital Monthly Important Message Updated as of 06/14/2017

*all red text is new for 06/14/2017

The following documents were recently updated:

CMAP Addendum B
The Department of Social Services (DSS) has updated the Connecticut Medical Assistance Program's (CMAP's) Addendum B effective for dates of service January 1, 2017 and forward.

Any procedure code adds, changes or deletes and APC weight changes with an effective date of January 1, 2017 was updated in the system on March 1, 2017. DXC Technology will re-process any impacted claims in a special claim cycle. The date of the special cycle will be announced in the near future and the hospital important message will be updated at that time.

Provider Manual Updates

Provider Manual Chapter 8 June 1, 2017 Updates - changing all logos and references from Hewlett Packard Enterprise to DXC Technology, as well as adding modifiers 76, BL, CA, JW, adding RCC 409 requirements and new procedure codes 77065 – 77067 and 97161-97168.

Provider Manual Chapter 12 Updates- changing all logos and references from Hewlett Packard Enterprise to DXC Technology, as well as updating the zip code for PO Box 5007. Explanation of Benefit (EOB) code 0512 was updated and EOBs, 0316, 0337, 0365, 0630 and 5927 have also been added.

Provider Bulletin 2017-29 – Provider Audit Trainings

The Department of Social Services (DSS) is offering free training directed to Connecticut Medical Assistance Program (CMAP) providers in an effort to help them improve compliance with Medicaid requirements under state and federal laws, regulations and policies. This will be done through increased knowledge of audit preparation, the audit process, common errors found during an audit and a discussion of the audit protocols. To sign up for the provider audit training go to http://www.ctdss.net/osdevents/.

The hospital outpatient audit training is scheduled for November 15, 2017 at Connecticut Valley Hospital – Merritt Hall from 9 AM – 12 PM.

Provider Bulletin 2017-28 – Updated Guidelines for Smoking Cessation Agents, Counseling and Treatment Products

Effective July 1, 2017 this policy transmittal supersedes PB 11-94, "Expansion of Smoking Cessation Agents, Counseling and Treatment". It seeks to remind providers of the Connecticut Medical Assistance Program (CMAP) policies related to individual smoking cessation and smoking cessation treatment products to update coding, and to clarify billing for individual smoking cessation counseling in the outpatient hospital setting must be performed in conjunction with a medical clinic, emergency department (ED) or behavioral health (BH) outpatient visit.

When individual smoking cessation counseling is provided by a licensed behavioral health clinician during an established behavioral health outpatient visit, the hospital may bill on behalf of the BH clinician. Outpatient hospitals must bill procedure codes 99406 and 99407 in conjunction with Revenue Center Code (RCC) 914 – Individual Therapy when individual smoking cessation occurs during an established behavioral health visit. Since BH services in the

outpatient hospital setting are paid using bundled rates, the BH clinician may not bill separately for professional services.

Effective for dates of service July 1, 2017 and forward, procedure codes 99406 and 99407 will be payable on CMAP's Addendum B only when performed as part of an established behavioral health visit, when the new CMAP Addendum B comes out in July.

As a reminder when individual smoking cessation is provided as part of a medical outpatient hospital clinic visit or an emergency department visit, the hospital is not eligible for additional payment under CPT codes 99406 and 99407. The non-behavioral health provider may submit for reimbursement as a separate professional claim.

Provider Bulletin 2017-26 – Expedited Medicaid Eligibility Processing for Individuals with Medical Emergencies

This bulletin is a reminder to providers about the availability of expedited Medicaid eligibility processing for individuals with medical emergencies. An individual may be eligible for emergency Medicaid application processing if the individual has a condition or illness that, if not immediately treated, places the individual at serious and imminent risk of severe harm or permanent disability.

Individuals who apply for assistance through www.accesshealthct.com and who are determined to be eligible for Medicaid receive a proof of coverage letter that guarantees payment of healthcare services when provided from Medicaid enrolled providers. Enrolled providers may rely on this letter as a guarantee of payment for 30 days from the date on the top of the eligibility notice as described in Provider Bulletin 2014-15, or, in many situations, providers may obtain a temporary client ID following instructions in Provider Bulletin 2014-29.

Provider Bulletin 2017-23 – Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule

The Department of Social Services (DSS) and DXC Technology published the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and 835 schedule for July to December 2017.

Update to the Consent to Sterilization Form Submission (Federal Form OMB No. 0937-0166), Hysterectomy Information Form (W-613) and Physician Hysterectomy Certification Form Retroactive Eligibility (W-613A) Submission Process

Effective immediately, hospital can fax their form submissions to DXC Technology at 1-860-986-7995.

The mailing address changed to DXC Technology PO Box 2971 Hartford, CT 06104.

Re-enrollment for Hospital

The hospitals are reminded to take note of their re-enrollment due date with Medicaid. Hospitals will be sent a re-enrollment notification letter six (6) months prior to their re-enrollment and we encourage the hospital to re-enroll as soon as possible. Failure to complete the re-enrollment process **by the re-enrollment due date** will cause the hospital to be dis-enrolled on the enrollment due date and no claims after that date will be allowed until the re-enrollment is completed.

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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.

Stamford Hospital re-enrollment due date 7/13/2017 – Outpatient Hospital
Midstate Medical Center re-enrollment due date 10/18/2017 – Inpatient Psychiatric Unit

Medically Unlikely Edit (MUE) EOB 770 "MUE Units Exceeded"

The Department of Social Services (DSS) is reviewing procedure codes units against Medicare's units. If the hospital feels there are additional procedure codes in question, the procedure code and ICN of the claim can be sent to ctxixhosppay@dxc.com.

- 6/13/2017 – Hospitals are inquiring how best to request a review of when to allow greater than MUE units. The hospitals are not questioning the MUE units set in the system. This would be a specific claim they would like reviewed to allow additional units. A process is currently being developed and the Department will provide guidance and billing instructions once system updates have been made. Please hold on to any reviews until further notice.

Outstanding Questions

Emergency Department Accident Related Request Forms

Hospitals are receiving a high number of Emergency Department Trauma related request forms looking for additional documentation. The hospitals are looking for a person at DSS to discuss why there are so many requests.

In April 2016 this process was automated and now the letters are generated and sent to providers systematically. This means that the volume that a hospital used to receive over a longer period of time (say a few months) is now being sent at one time since manual intervention is no longer needed. The Department and DXC Technology believe that the same volume is being sent to each hospital, but that it feels different to the hospital because the time span in which that volume is received has been significantly shortened.

As an additional note: DXC Technology has in the past reviewed the diagnosis codes flagged as part of the trauma criteria to remove codes that really are not trauma/accident related (i.e. bee stings), but they will once again review to ensure that they have captured and removed everything that clearly does not make sense. DXC Technology said that now that the process is systematic they will have the ability to "track" the volume of letters generated and sent to the hospitals to see if there is indeed a spike moving forward. There was no spike in the volume of letters being sent. The volume has been steady each month.

- 6/13/17 - DXC Technology verified there was no increase in the volume of letters being sent to the hospital due to new ICD-10 codes. The letters are only sent out once a month to the hospitals. Due to the high number of letters being sent to the hospitals each month DXC Technology and DSS are reviewing the trauma criteria for these letters to be sent and the hospitals have asked at the May 10, 2017 patient account managers meeting what does DSS due with all the information gathered from these letter. The question was sent to the department and DXC Technology is waiting for additional information.

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National Drug Code billing

- 6/13/2017 – When hospitals bill two different NDCs on two different detail lines using the same HCPCS codes, the second detail line is being denied as a duplicate. The second detail is denying even when the hospital has received PA for these services or these services are payable, non-packaged code according to CMAP's Addendum B. DXC Technology and DSS have reviewed this issue and will be making a system update to bypass the duplicate edit in times when the NDC code is different. There is no scheduled date of completion and hospitals should continue to bill as they are today. The important message will be updated once the system update is scheduled.

Reduced/Discounted services

- 6/13/2017 - 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." The hospitals have asked that DSS review this and DSS has agreed to review and if they decide to make any changes the important messages will be updated at that time.

Inpatient Admit Changes from Medical to Psychiatric

When a HUSKY client is admitted and the primary reason for the admission is medical in nature, the hospital should request a medical PA from CHNCT to process the authorization through discharge. If the client is subsequently transferred to a psychiatric unit, the hospital should administratively discharge (Patient Status 65) the client from medical and re-admit the client to behavioral health (Admit Source D) to qualify for the per diem rate for the behavioral health portion of the stay. Upon re-admission to behavioral health, the hospital should request a per diem PA from CT BHP to process the authorization through discharge. In this case, the hospital must submit two separate inpatient claims, with two different admit dates.

6/1/2017 - DXC Technology has identified an issue with inpatient admissions that change from medical to psychiatric. In cases where the behavioral health inpatient prior authorization is longer than the actual inpatient behavioral health stay could cause the inpatient claim to pay incorrectly. Previously we asked the hospitals to contact Beacon Options to update the current inpatient behavioral authorization. The hospitals should no longer contact Beacon Options to update an inpatient authorization in these situations and wait for the system update. The system is tentatively scheduled to be update in June to allow these claims to be re-submitted and once it is updated the hospital important message will be updated.

Reminders:

Digital Breast Tomosynthesis

- 5/10/2017 – Provider bulletin 2017-16 "Digital Breast Tomosynthesis – Outpatient Hospital Billing" effective for dates of service July 1, 2016 and forward, digital breast tomosynthesis services must be billed under Revenue Center Code (RCC) 409 – Other Imaging Services and one of the following Current Procedural Terminology (CPT) codes 77061 – 77063 and it will be reimbursed based on the Physician Radiology Fee Schedule.

State Specific Tool for APC Processing

- 4/1/2017 - 3M has released the CT Medicaid reimbursement solution and is providing customers who license this solution with the standard APC grouper/editor. 3M is currently working on modifying the edits to emulate how CMAP processes claims. This

version will be available in a future release. If the hospitals are interested in obtaining more information on 3M software, they can contact: Dave Jenkins, Account Manger dajenkins@mmm.com Office phone: (610) 458-9747.

Inpatient Only Procedures

- 4/11/2017 - If the hospitals believe there are any procedures that should be reviewed by the Department to be eligible for reimbursement in an outpatient hospital setting, please send the list of procedure codes and a **brief justification** as to why the service can be performed in an outpatient setting to ctxixhosppay@dxc.com. Any previous request that were submitted without justification will not be reviewed.

Inpatient delivery stays denying due to lack of prior authorization when the delivery stays do not require prior authorization.

The Department of Social Services' (DSS) criterion for identifying a delivery for an inpatient stay is based on the primary diagnosis code on the claim. If the primary reason for the stay was a delivery, then Prior Authorization (PA) is not required. DSS has determined that there were ICD-10 diagnosis codes that should have bypassed the PA requirement on an inpatient delivery stay. The following diagnosis codes were recently updated to be billed as the primary diagnosis which will bypass PA on a delivery inpatient stay:

O34.513, O41.1220 – O41.1222 – O41.1230- O41.1232 and O90.81

If the hospital still believes there are other diagnoses that should be considered to bypass PA when a delivery occurs, please send claim examples (including ICN) to DXC Technology at the following e-mail address: ctxixhosppay@dxc.com.

Previous diagnosis codes that were denied by DSS, either had a childbirth specific diagnosis code in the series, which is the appropriate code to use instead of the trimester code (i.e. O10.013 "Pre-existing essential hypertension complicating pregnancy, third trimester", if there was a delivery the hospital should use O10.02 "Pre-existing essential hypertension complicating childbirth" or were denied because the diagnosis code in question should not be considered as the primary code on the claim. In other circumstances, the hospital should be using a more specific code under ICD-10 versus selecting "unspecified".

HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) and DXC Technology will be closed on Tuesday July 4, 2017 in observance of the Independence Day Holiday. DSS and DXC Technology will re-open on Wednesday July 5, 2017.