interChange Provider Important Message

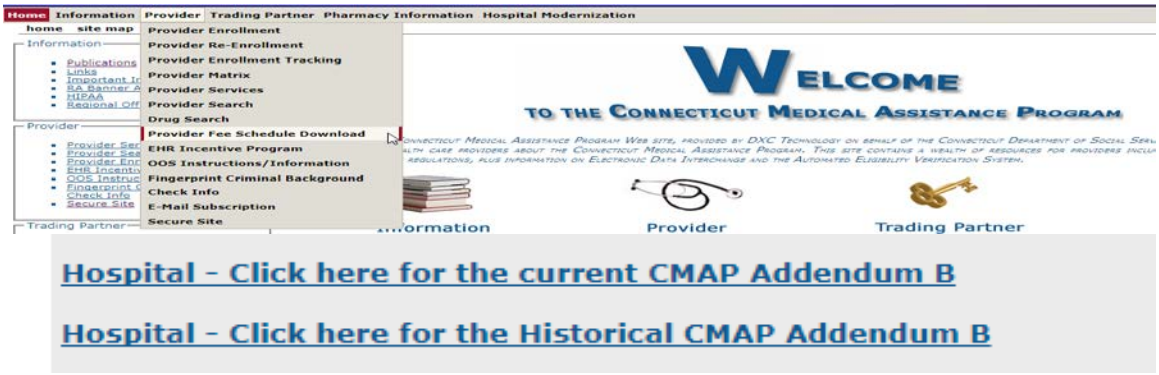
Hospital Monthly Important Message Updated as of 11/08/2017

*all red text is new for 11/08/2017

The following documents were recently updated:

CMAP Addendum B
The date of the special cycle will be announced in the near future and the hospital monthly important message will be updated at that time for dates of services January 1, 2017 to March 1, 2017.

The October version of CMAP Addendum B is posted on the hospital modernization page on the www.ctdssmap.com under the "Hospital Modernization" link. Current and historical versions of the Addendum B were also added under the provider fee schedule page.



Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system with an October 1, 2017 effective date. Any claim with a status indicator of G or K for dates of service October 1, 2017 and forward have been reimbursed the updated rate. Any other procedure code adds, changes, or deletes with an effective date of October 1, 2017 and forward was updated on November 7, 2017.

3M Grouper

System updates to start processing using APR-DRG V35 was completed on November 7, 2017. Due to the update with the ICD-10 (International Statistical Classification of Diseases) diagnosis codes and surgical procedure codes, inpatient DRG claims with header Through Date Of Service (TDOS) October 1, 2017 and forward were being suspended with either Explanation of Benefit (EOB) code 0693 "Invalid Principal Diagnosis" or EOB code 0920 "3M Grouper Error." These claims will be released for processing in the November 17, 2017 claim cycle.

Inpatient claims with From and Through Dates of Service overlapping October 1, 2017 that were submitted with a new ICD-10 surgical procedure code effective October 1, 2017 with a date prior to October 1, 2017 will deny with EOB code 4067 "Non-Covered ICD Procedure Code". DXC Technology is currently working on a system fix and once completed the hospitals will be able to re-submit their claims.

DRG Calculator Updated November 7, 2017

The DRG calculator was updated and has been added to Hospital Modernization Web page for inpatient discharges October 1, 2017 and forward. This includes an update to the DRG Tables

effective for October 1, 2017. Historical DRG calculators will be under a new link called "DRG Calculator Historical Version".

Provider Bulletin 2017-70 – Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health and CADAP Programs)

The Department of Social Services (DSS) and DXC Technology has published the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and 835 schedule for January 2018 to June 2018.

Provider Bulletin 2017-69 – Medically Unlikely Edits Review Process

The Department of Social Services (DSS) is implementing a process for reviewing claims denied solely due to exceeding the National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) limit for dates of service July 1, 2016 and forward.

Hospital can request DSS review of claims with denied details due to exceeding an MUE with Explanation of Benefits (EOB) Code 770 "MUE Units Exceeded". Claim details over the assigned MUE limit will be denied even if there is an approved prior authorization (PA) that would otherwise allow coverage of the service.

If a service denies solely due to exceeding the NCCI MUE limit, providers may submit a request to have the claim reviewed. An electronic claim must be submitted following the guidelines set forth in Provider Bulletin 2017-49, "Electronic Claim Submission with Paper Attachment Process" for an MUE review. It must list all the services rendered on the denied claim. The detail that exceeded the allowed MUE must be broken out into two separate details. The first detail line should be submitted with the allowed MUE units and the remaining units must be submitted on a separate detail with the GD modifier. The electronic claim will be suspended for review with Explanation of Benefit (EOB) code 772 "Unit of Service > MUE and Claim Paid/Denied after policy review".

If the original claim was partially paid it should be voided and the claim should be re-submitted electronically following the guidelines set forth in Provider Bulletin 2017-49 when the provider wants the claim to be reviewed for MUE units.

Provider Bulletin 2017-64 – New Clinical Guidelines - Prior Authorization Electric Tumor Treatment Field Therapy

Effective November 1, 2017, new clinical 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 electric tumor treatment field therapy. The new policy is available on the HUSKY Health Web site at: www.ct.gov/husky. To access the policy, click on For Providers followed by Policies, and then Procedures and Guidelines under the Medical Management menu item.

Provider Bulletin 2017-29 – Provider Audit Trainings - Cancelled

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/.

interChange Provider Important Message

Closed Questions / Issues

Inpatient Behavioral Health Claims

DXC Technology previously identified an issue with inpatient behavioral health claims incorrectly reimbursing the entire claim when there were not enough Prior Authorization (PA) units to cover the entire inpatient stay. The impacted claims were identified and reprocessed and appeared on the September 12, 2017 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52. The inpatient claims were adjusted to pay the correct number of days per the Prior Authorization (PA) on file.

If the hospital received 2 PAs from Beacon Health Options for the one inpatient admission, the claim was reprocessed only using 1 PA on file. The reprocessed inpatient claim only had one room and board detail on the claim thereby not using all the units from both PAs, causing the claim to cut-back the reimbursement. DXC Technology is currently reviewing the issue and will update the hospitals once a resolution is reached.

Outstanding Questions

Outpatient Therapies Claims

- 11/1/2017 - 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 has reviewed the outpatient claims and is working on system updates.

CMAP Addendum B Questions

Status Indicator G "Drug Biological Pass Through" and K "Non-Pass-Through Drugs and Biologicals"

If the procedure codes payment type is APC-PR with a status indicator of G or K, it will be reimbursed based on the payment rate on CMAP Addendum B x the number of units up to the detail billed charges. We will pay the lesser of billed charges and the payment rate. We only allow more than the detail amount when the claims process at an APC rate.

CMAP Addendum B Payment Rate field

If the Payment Rate field on the CMAP addendum B has an amount in the payment rate field that is grayed out the hospitals should ignore that field. The hospitals should refer to the payment type or status indicator fields to determine how payments are made.

Reminders / Updates

Medical and Behavioral Health Hospital Readmissions on the Same Date of Service.

When a member is discharged from an acute care hospital and subsequently readmitted to the same hospital on the same date of service for symptoms related to the original admission, the original and subsequent stay must be combined onto a single claim. The applicable Administrative Service Organization (ASO), Community Health Network of Connecticut (CHNCT) or Beacon Health Options must be notified of the subsequent inpatient admission so that the original authorization can be modified to cover both admissions.

If a member is discharged from an acute care hospital and readmitted on the same date of service for symptoms unrelated to the initial admission, the hospital must request a second

prior authorization from the applicable ASO. The hospital must have a second authorization on file to allow separate claims to pay.

If the initial inpatient stay is medical in nature and the subsequent admission is behavioral health in nature, two separate claims may be submitted for reimbursement. Prior authorization must be obtained from each of the applicable ASOs for both admissions.

Primary Insurance denying claim due to not receiving information (TPL survey) from client, then billing to Medicaid.

- In cases where the primary insurance to Medicaid is denying the claim due to not receiving information from the client, the hospital should use the Legal Notice of Subrogation Form (W-81) when initially pursuing commercial health insurance. This puts the insurance company on legal notice that it must make any payment for which it is liable for directly to the provider.

- If the hospital does not receive payment within forty-five days, they should fully document that every reasonable attempt was made. The provider must file a request for assistance with the Connecticut Department of Insurance using form W-82, Request for Assistance in Obtaining Payments. Department of Insurance will furnish the hospital with a file/case number.

- DSS is aware that other insurance carriers never cover some services. In addition, there are some insurance companies that do not provide an actual denial statement or, in some cases, never respond to written requests. To address these problems and to alleviate any unnecessary burden on the provider, DSS implemented the Third Party Billing Attempt, (W-1417). This form documents that the hospital has made every attempt to obtain payment from the other insurance carrier prior to claim submission to the Connecticut Medical Assistance Program. The form may be used in place of a denial voucher for the other insurance carrier, but may not be used in place of a Medicare denial. If the provider has not received any insurance payment within ninety days of the **date of the initial claims submission**, then the provider may bill the Connecticut Medical Assistance Program. **The Department of Insurance file number is required on the W-1417 form. Failure to include the Department of Insurance file number will result in the claim being returned to the provider.**

These instructions can be found under Provider Manual Chapter 5 "Claim Submission Information" on the www.ctdssmap.com Web site under the hospital modernization page, by clicking on Provider Manuals on the right side of the page. The forms can be downloaded from the www.ctdssmap.com Web site, under Information and then Publications and scrolling down to Third Party Liability Forms.

For any additional questions, the hospitals can contact the TPL unit at DSS.

Medicare Covered Services Only – Qualified Medicare Beneficiary (QMB)

If the client is Qualified Medicare Beneficiary (QMB) Medicare Covered Services only, they can bill the client for non-covered services since Medicaid only considers the claim as secondary when there is a Medicare co-insurance and/or deductible amounts.

Please see MLN https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf for additional information. If the hospital is determining whether to bill the clients for Inpatient Part A claims denied by Medicare due to benefits being exhausted, the hospital needs to contact the Centers for Medicare & Medicaid Services (CMS) for guidance.

interChange Provider Important Message

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 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 future:

Danbury Inpatient Rehabilitation Hospital - 12/31/2017
Midstate Medical Outpatient Hospital - 01/22/2018

Provider Manual Chapter 8 – Updated October 31, 2017

Provider manual chapter 8 has been updated to reflect the following updates: modifier GD was added under the Modifier section of Billing Instructions; procedure code 96125 was added under Physical and Occupational Therapy Revenue Center Codes (RCCs); and procedure code 96105 was added under Speech Therapy RCCs.