interChange Provider Important Message

Hospital Monthly Important Message Updated as of 07/11/2018

*all red text is new for 07/11/2018

The following documents were recently updated:

CMAP Addendum B July 1, 2018

The updated version of the CMAP Addendum B and NEW procedure codes is tentatively scheduled to be updated July 31, 2018 with an effective date of July 1, 2018 and forward.

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system prior to July 1, 2018. Any claims that are submitted for dates of service July 1, 2018 and forward that have a status indicator of G or K will process at the correct payment rate.

CMAP Addendum B Reprocessing Timeline

CMAP Addendum B Version	Effective Date	Updated	Adjustment Dates	Tentative Target Date
V17.2	July 1, 2016	September 28, 2016	July 1, 2016 – September 27, 2016	**Mid Aug 2018**
V17.3	October 1, 2016	November 30, 2016	October 1, 2016 to November 29, 2016	**Mid Aug 2018**
V18.0	January 1, 2017	March 1, 2017	January 1, 2017 to February 28, 2017	**Mid Aug 2018**
V19.0	January 1, 2018	February 28, 2018	January 1, 2018 to February 27, 2018	**Mid Aug 2018**
V19.1	April 1, 2018	May 10, 2018	N/A	
V19.2	July 1, 2018	**Tentative Date July 31**	TBD	

DXC Technology will be adjusting claims with APC weight changes, status indicator changes, "NEW" codes and other change indicated by an "X" in the change field on the CMAP.

Outstanding Questions

Outpatient Therapies Claims

- 7/1/2018 - The hospitals have requested DXC Technology to review outpatient therapy 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 identified an outpatient therapy issue were the therapy claims were paid over the flat rate due to duplicate payments for one date of service.

  The system was updated to correct both of these issues on April 24, 2018. DXC Technology has reprocessed any claims that paid less than or greater than the flat rate. The ID and reprocess occurred in the 2nd cycle in June and appeared on your June 26, 2018 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

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Advanced Beneficiary Notice (ABN) Forms

- 6/1/2018 - Hospital claim denied for Explanation of Benefit (EOB) code 2502 "Bill Medicare First." The hospital has an Advanced Beneficiary Notice (ABN) form and in this case is not billing Medicare first. At this time there are only posted instructions for home health providers when there is an ABN form and there are no specific instructions for hospitals to follow. Changes in processing guidelines may have implications beyond hospitals so DSS and DXC Technology are still reviewing billing guidelines for all providers including hospitals.

Inpatient DRG Claims in Suspended Status

Inpatient Diagnostic Related Group (DRG) hospital claims are currently displaying the claim status as "Adjusted/Voided" or "Suspended" under claim inquiry on the www.ctdssmap.com Web site.

To identify the suspended claims, the Internal Control Number (ICN) will begin with 5518125 through 5518127 and the claim will be in a "Suspended" claim status. The original claim will be in an "Adjusted / Voided" claim status.

DXC Technology previously identified inpatient DRG claims that paid at the incorrect DRG code, DRG weight or organ transplant rate. In the June 22, 2018 claim cycle, DXC has reprocessed the inpatient claims that paid differently due to DRG code, DRG weight or organ transplant rate changes and the reprocessed claims appeared on your June 26, 2018 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 55.

Reminders / Updates

Provider Bulletin 2018-43 - Removal of Authorization/Registration for Behavioral Health Professional Services Rendered in an Emergency Department

Effective for dates of service July 1, 2018 and forward, prior authorization (PA)/registration will no longer be required for behavioral health professional services when rendered in Place of Service (POS)/Facility Type Code (FTC) 23 – Emergency Department (ED).

Although PA/registration will be removed in POS/FTC 23 (ED) – hospitals should be in contact, at least daily, with the Department of Social Services Behavioral Health (BH) Administrative Services Organization – Beacon Health Options regarding the status of patients waiting for a BH placement at an alternate facility that provides behavioral health services.

Consistent with Sec. 17b-262-971(c) (1) (2) of the Regulations of Connecticut State Agencies Concerning Outpatient Hospital Services, physicians (including psychiatrists, advanced practice registered nurses (APRNs) including psychiatric APRNs, psychologists and behavioral health clinicians such as licensed clinical social workers and licensed professional counselors) can bill for and be separately reimbursed for medically necessary BH services rendered in POS/FTC 23 (ED). The procedure codes billed must be on the applicable provider's fee schedule and within the practitioner's scope of practice.

As a reminder outpatient hospital BH services are considered an all-inclusive rate and professional fees will not be reimbursed separately for medically necessary services rendered in POS/FTC 19 (off campus-outpatient hospital) or 22 (on campus-outpatient hospital).

Provider Bulletin 2018-39 - Diagnostic Related Group (DRG) Coding Reviews

In the next few months, the Department of Social Services (DSS) will begin conducting reviews of inpatient hospital claims paid under a Diagnostic Related Group (DRG) methodology to ensure DSS is

reimbursing the proper amount for these claims in conformance with Medicaid and DSS policy. These post payment reviews will be conducted by DSS's contractor, Health Management Systems, Inc. (HMS).

Additional information and instructions will be provided to the hospitals by HMS at the beginning of the review process. If you have any questions about the information in this bulletin, please contact CT_Medicaid_State@hms.com.

Provider Bulletin 2018-38 - Increasing the Reimbursement Rates for Select Long-Acting Reversible Contraceptive Devices

The Department of Social Services (DSS) is updating the reimbursement rates for select Long-Acting Reversible Contraceptive (LARC) devices for dates of service July 1, 2018 and forward.

Reimbursement for LARC devices in the outpatient hospital setting will be determined by the specific procedure code billed for the LARC device inserted/placed.

The reimbursement rate for LARC devices will be the rate published for the specified procedure code on the physician office and outpatient services fee schedule or, for 340B hospitals, the clinic - family planning / abortion fee schedule. Hospitals should utilize Connecticut Medical Assistance Program (CMAP) Addendum B to determine the payment type for outpatient hospital procedures.

Provider Bulletin 2018-35 - Documentation Guidelines for Evaluation & Management Services Performed by Students

The Department of Social Services (DSS) is issuing guidance regarding documentation and billing guidelines for evaluation and management (E/M) services when performed by a student in the presence of a teaching physician. This provider bulletin does not change the requirements in PB 2016-82 – Revised: Documentation and Billing Guidelines for Services Performed by Residents, which remains in effect.

DSS will follow The Centers for Medicare and Medicaid (CMS) requirements as outlined in the Medicare Learning Network (MLN) MM10412 – E/M Service Documentation Provided by Students.

Provider Bulletin 2018-34 - Enhanced Secure Web Site Features for Password Resets, Locked Accounts, and Disabled Accounts

The Department of Social Services (DSS) had implemented additional self-service functionality for master users (both providers and trading partners) and their clerks to allow them to more easily reset their passwords, unlock their accounts when a user has exceeded their password attempts, and reactivate their accounts if they have not been used within the last ninety (90) days.

In order to implement this functionality, all existing Secure Web portal account users will be presented with increased site security panels the next time they log in to their Secure Web portal account.

The increased site security process consists of all users providing two (2) updated security questions and answers and an updated email address

Provider Bulletin 2018-31 - Revised Medicaid (HUSKY) Spend-down Procedures

The Department of Social Services (DSS) made some changes to the way it processes Medicaid (HUSKY) "spend-down" cases. DSS has updated the address and form used to submit HUSKY spend-down medical expenses.

Hospitals with questions can call the HUSKY Spend-down Processing Center Monday through Friday, from 8:30 am to 5:00 pm at 1-877- 858-7012.

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Effective immediately, hospitals should now send medical expenses submitted on behalf of spenddown clients to:
DSS ConneCT Scanning Center
P.O. Box 1320
Manchester, CT 06045-1320

Family Planning Services Only Benefit Plans

Family Planning Services Limited benefit provides confidential coverage for select family planning services when the primary reason for the visit is to prevent pregnancy or limit/regulate the number and spacing of children. Coverage is also provided for limited family planning related services, which are provided as part of or as follow up to the primary family planning visit.

Please refer to table 3a in the Fee Schedule Instructions labeled Family Planning Service Diagnosis Codes. From the Web site www.ctdssmap.com under provider click on → provider fee schedule download → Fee Schedule Instructions link then scroll to table 3a for a list of ICD-10 Diagnosis codes that are covered under the Family Planning Services Only benefit plan. The hospital claim will deny with Explanation of Benefits (EOB) code 4742 "The procedure is not consistent with the header diagnosis."

For additional eligibility information on other benefit plans please refer to the Eligibility Response Quick Reference Guide located under publications on the Web site www.ctdssmap.com or under the provider's secure site under eligibility.

ASC X12N Health Care Eligibility/Benefit Inquiry and Information Response (270/271)

- 7/1/2018 - The hospitals have requested if DXC can make updates to the ASC X12N Health Care Eligibility response file 270/271 to allow eligibility searches based on date of birth and name, and not require a social security number. DXC/DSS is currently working on updating the 270/271 transaction with a tentative completion date of July 31, 2018.

Inpatient Hospital Fee Schedule for Organ Acquisition Costs

The table below contains historical and current Organ Acquisition rates for both in- and out-of-state hospitals for Revenue Center Code (RCC) 810, 811 and 812.

Organ	Flat Fee	Effective date	End date
Kidney	$82,289	7/1/2018	12/31/2299
Heart	$87,194	7/1/2018	12/31/2299
Liver	$164,760	7/1/2018	12/31/2299
Pancreas	See Below	7/1/2018	12/31/2299
Lung	See Below	1/1/2015	12/31/2299

Payment will be the lower of charges or state wide average.
*For lung or pancreas acquisition, the hospital must submit their most recent Medicare cost report submitted to CMS.