September 2015
Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- Understanding the NCCI Edits
- ICD-10 Related Billing Changes
- Elimination of Provider Electronic Solutions (PES) Software
- Ambulatory Payment Classification (APC) Scheduled for March 1, 2016

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Understanding the NCCI Edits

The Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments. The Patient Protection and Affordable Care Act (ACA) required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010.

NCCI policies and edits address procedures/services performed by the same provider for the same beneficiary on the same date of service.

NCCI includes two types of edits: NCCI Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUE).

1. NCCI Procedure-to-Procedure (PTP) edits have a Column 1 and Column 2 HCPCS/CPT code. If the two codes of an edit pair are reported for the same patient on the same date of service, the Column 1 code is eligible for payment but the Column 2 code is denied unless an appropriate NCCI-associated modifier is allowed and reported. The Column 2 code is often a component of a more comprehensive Column 1 code. (For example, since a cardiac stress test includes multiple electrocardiograms, an electrocardiogram is not separately reportable.
2. Medically Unlikely Edits (MUEs) prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code represents the maximum number of units of service reportable by the same provider for the same patient on the same date of service.

Every quarter new NCCI Edits are added. The 1st quarter begins on January 1; the 2nd quarter begins on April 1; the 3rd quarter begins on July 1; and the 4th quarter begins on October 1 of each year. Providers are asked to download the NCCI Edit files that are applicable to their practice at the start of every quarter. There are a few different edit files available for download from the CMS website depending on the provider type and the edit type (not all files may be applicable to Connecticut Medical Assistance Program enrolled providers):

- PTP edits for practitioner and ambulatory surgical center (ASC) services.
- PTP edits for outpatient hospital services (including emergency department, observation, and hospital laboratory services).
- PTP edits for durable medical equipment (as of October 2012).
- MUEs for practitioner and ASC services.
- MUEs for outpatient hospital services for hospitals.
- MUEs for durable medical equipment

Additional resources, listed below, are available to providers who wish to learn more about the NCCI edits.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf

https://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/FAQ-Medicaid-NCCI.aspx

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All Providers

ICD-10 Related Billing Changes

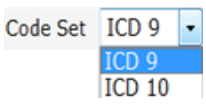
HIPAA rules mandate that ICD-10 Code Sets be used for any services rendered for dates of service October 1, 2015 forward. Providers should take steps to learn and use the ICD-10 Codes appropriately. ICD-10 implementation requires certain global billing changes. The ID code qualifier for ICD-10 codes is different than the ID code qualifier for ICD-9 codes. Providers need to be aware of the correct ID code qualifier to be submitted for the different ICD versions.

Noted below are billing changes required for billing with ICD-10 Code Sets. The changes for the 837 transactions are noted in the Implementation Guide for the different claim types. The Web Claim Submission Instructions and Chapter 8 of the Provider Manual for all provider types will be updated in the near future to include these billing instructions.

Global 837 Changes: The ICD-10 Code Sets should be submitted with the appropriate ID Code Qualifiers.

Diagnosis ID Code Qualifier for ICD-9	Diagnosis ID Code Qualifier for ICD-10
BK - Primary Diagnosis	ABK
BJ - Admit Diagnosis (Institutional)	ABJ
BN - Ecode Diagnosis (Institutional)	ABN
BF - Other Diagnosis	ABF
PR - Visit Diagnosis (Institutional)	APR
BR - Principal Procedure Code (Institutional)	BBR
BQ - Other Procedure Code (Institutional)	BBQ

Global Web Claim Changes:
Diagnosis panels currently have a drop down list to select either the ICD-9 or ICD-10 Code Set.



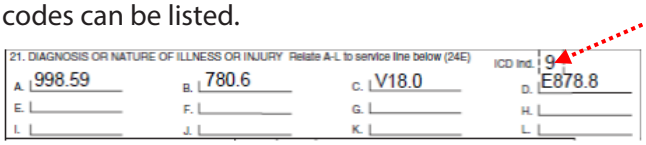
Please Note: For Institutional claims, in addition to selecting the Code Set for Diagnosis tab, providers will have to select the Code Set for Cause of Injury and Reason for Visit diagnosis tabs. Inpatient and Inpatient crossovers will need to select the Code Set for Surgical Procedure.

Professional Paper Claim Changes: The specific ICD-10 changes are noted below:

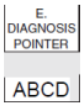
Item Number 21 Diagnosis or Nature of Illness or Injury: Providers will enter the applicable ICD indicator to identify which version of ICD codes is being reported.

- 9 for ICD-9-CM
- 0 for ICD-10-CM

No more than 12 ICD-9-CM or ICD-10-CM diagnosis codes can be listed.



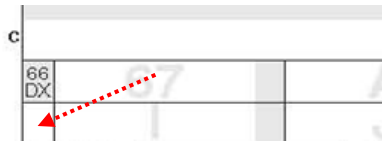
Item Number 24E Diagnosis Pointer:
Providers will enter the diagnosis code reference letter (pointer) as shown in Item Number 21 on the version 02/12 CMS-1500 claim form. When multiple services are performed, the primary reference letter for each service should be listed first. The reference letter(s) should be A – L or multiple letters as applicable. Alpha characters only are accepted.



Institutional Paper Claim Changes: The specific ICD-10 changes are noted below:

Item Number 66 DX: Providers will enter the applicable ICD indicator to identify which version of ICD codes is being reported.

- 9 for ICD-9-CM
- 0 for ICD-10-CM



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All Providers

ICD-10 Related Billing Changes

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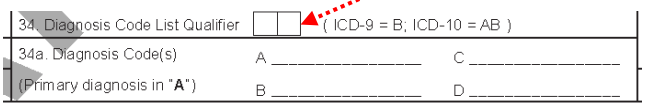
Dental Paper Claim Changes: The specific ICD-10 changes are noted below:

Item Number 34 Diagnosis Code List Qualifier:
Providers will enter the applicable ICD indicator to identify which version of ICD codes is being reported.

- B for ICD-9-CM
- AB for ICD-10-CM



It is important to note that ICD-10 codes may only be used for services provided on or after October 1, 2015. A claim cannot contain both ICD-9 codes and ICD-10 codes.

Stay Informed: DSS and HP are maintaining an ICD-10 Important Message on the Home page of our Web site at www.ctdssmap.com. The ICD-10 Important Message contains links to key CMS-support materials, external provider resources, and training documentation to aid in the successful implementation of ICD-10. We urge our providers to check this Important Message frequently to stay informed for a successful implementation of ICD-10.

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Timely Filing Changes to Claim Adjustments

System changes have recently been made to allow providers to return a previous claim payment via a claim adjustment without the claim denying in full for exceeding the timely filing limit. Claim adjustments will no longer deny for exceeding the timely filing limit if the adjustment results in a payment equal to or less than the original claim payment. Providers may now submit these types of adjustments via the Web or an 837 adjustment transaction. Providers no longer need to submit paper Paid Claim Adjustment Forms (PCARS) or a check to give back an overpayment.

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Avoiding 1912 Denials (Billing Provider's Taxonomy is Missing)

If you are receiving Explanation of Benefit (EOB) code 1912 denials on your Medicare Crossover claims, the root cause is usually the lack of a taxonomy. If you have more than one taxonomy for your billing provider NPI, it is important that you send the correct taxonomy code for your billing provider number in the 2000A PRV segment when billing an 837 electronic claim. This is necessary whether you submit claims to Medicare first then expect them to crossover to Medicaid, or if you are submitting claims to Medicaid directly.

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Elimination of Provider Electronic Solutions (PES) Software for All Non-Long Term Care Claim Submissions/Claim Status Transactions

HP previously communicated to providers in provider bulletin PB2013-74, that effective October 1, 2014, Provider Electronic Solutions (PES) would not be upgraded to ICD-10 and would be phased out. Instead, the Department of Social Services (DSS) chose to upgrade PES software to version 3.81 for claim submission (837I) transactions for Long Term Care (LTC) providers to accommodate the ICD-10 mandate which will be implemented on October 1, 2015 and client batch eligibility verification transactions (270/271) for all providers. This version has been available since October 29, 2014. LTC providers who currently use the "837 Institutional Nursing Home" for claim submissions/claim status, or all other providers that use the "270 Eligibility Request" for batch eligibility verifications only are encouraged to upgrade to version 3.81 as soon as possible. In order to upgrade to version 3.81, you must have sequentially installed all previous versions and currently have version 3.80 installed. To verify the current version you are running, click the "Help" icon in the software menu and click on "About".

Non-Long Term Care Providers:

Non-LTC providers that use PES for non-LTC claim submissions/claim status transactions that have not upgraded to version 3.81 may continue to submit claims with ICD-9 via PES with dates of service through September 30, 2015. Important: Non-LTC providers that choose to upgrade to version 3.81 will lose their ability to submit non-LTC claims/claim status transactions via PES immediately. Non-LTC providers are required to transition to an alternative method for claim submissions/claim status before October 1, 2015 as these transactions will no longer be accepted via PES.

Long Term Care providers:

LTC providers may use the upgraded PES version 3.81 for claims billed with ICD-9 codes with dates of service through September 30, 2015. Once logged in, click on the "Forms" icon in the software menu then click on "837 Institutional Nursing Home". Header 3 will allow you to choose a qualifier from the drop down menu to identify which version of ICD codes is being reported. Choose ICD-9 for claim dates of service through September 30, 2015 or choose ICD-10 for claim dates of service on or after October 1, 2015.

Please refer to provider bulletins PB2014-50 and PB2014-63 for additional information regarding these changes.

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CHC Service Providers and Home Health Providers

CHC Monthly Claim Reprocessing

As a reminder, HP will continue their practice of voiding and resubmitting claims in the first cycle of each month for paid claims impacted by changes made to a Prior Authorization (PA), by the Access Agencies, two months prior to the month scheduled for reprocessing. Voided claims will appear with an Internal Control Number (ICN) beginning with region code 52 in the adjustment section of the Remittance Advice (RA) with an Explanation of Benefit (EOB) code 8236 - "Claim was recouped due to a PA change". The resubmitted claims will appear with an ICN beginning with region code 24 in either the paid or denied section of the RA, depending on the changes made to the PA, with an EOB code 8238 - "Claim Systematically Reprocessed Due to a PA/Service Order Change". Claims voided and resubmitted with no financial impact to the provider will not appear on the PDF version of the RA. These claims, however, will appear on the 835 and can also be accessed under claim inquiry on your secure Web portal account. The reprocessed claims will appear with region code 24 with EOB code 8237 - "Claims Systematically Reprocessed Due to a PA Change-Information Only". PLEASE NOTE: Claims with no financial impact will not be reflected in the "current summary" totals of the RA. However, the Month-To-Date and Year-To-Date totals will reflect these claims.

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Outpatient Hospitals

Ambulatory Payment Classification (APC) Scheduled for March 1, 2016

DSS will move from the current system of hospital outpatient payment methodology based on Revenue Center Codes (some paid based on fixed fees, some based on a ratio of costs to charges) to a prospective payment system based on the complexity of services performed. This change is scheduled for March 1, 2016.

The reasons for the move to APCs is to streamline policy to be consistent with industry standard payment practices (specifically, Medicare payment policy) and maintain a long-term commitment to goals of improved accuracy, predictability, equity, timeliness, and transparency of hospital payments for all Medicaid beneficiaries.

In the future hospitals will be able to refer to the Hospital Modernization Web page on the www.ctdssmap.com Web site for information pertaining to the APC implementation.

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340B Hospitals

340B Hospital Billing Changes

Effective for dates of service September 1, 2015 and forward, a valid National Drug Code (NDC) will be required when billing specific pharmacy Revenue Center Codes (RCCs) on an outpatient claim. Providers identified as 340B providers by the Office of Pharmacy Affairs (OPA) have previously been exempt from submitting NDCs on their claims. Outpatient 340B Pharmacies will be required to bill a valid NDC code with the following RCCs: 250-253, 258-259, and 634-637.

NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers. NDCs submitted in any configuration other than the 11-digit format will be rejected/denied.

All claim details with these RCCs that are not billed with a valid NDC will deny for Explanation of Benefit (EOB) code 0861 whose description is changing from "NDC is missing or Invalid" to "NDC is missing, invalid or non-rebateable".

Outpatient 340B Pharmacies must include NDC units of measurement and NDC quantity on an outpatient claim. If the hospital fails to bill with a valid NDC and the corresponding units, the service will deny with the following EOB codes: 0841 - "Units of Measure Required for NDC" or 0842 - "NDC units Missing or Invalid".

Professional 340B providers submitting a HCPCS drug procedure code in the J, S or Q series are also required to provide a valid corresponding 11-digit NDC as well as an NDC unit of measurement and NDC quantity on the professional Claim or the service will deny with the following EOB codes:

- 0861 - "NDC is missing, invalid or non-rebateable"
- 0841 - "Units of Measure Required for NDC"
- 0842 - "NDC units Missing or Invalid"

Please refer to the provider drug search on the Web to determine the corresponding HCPCS code. A drug search can be performed at the Web site www.ctdssmap.com, by selecting "Provider" then "Drug Search" and entering the NDC.

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Appendix

Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
9/7/2015	Labor Day	Closed	Closed
10/12/2015	Columbus Day	Open	Closed
11/11/2015	Veteran's Day	Open	Closed
11/26/2015	Thanksgiving Day	Closed	Closed
11/27/2015	Post-Thanksgiving Day	Closed	Open

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Appendix

Provider Bulletins

Below is a listing of Provider Bulletins that have recently been posted to www.ctdssmap.com. To see the complete messages, please visit the Web site. All Provider Bulletins can be found by going to the Information -> Publications tab.

PB15-67 Billing Requirements to Identify a Distinct/ Separate Urgent, Clinic or Emergency Visit
PB15-64 Revised Billing Instructions for Outpatient 340B Pharmacies on Outpatient Claims
PB15-63 Provider Enrollment for New CT Home Care Program Services
PB15-62 Changes to the Reimbursement for Physician Pathology, Medicine and Surgical Services with a Professional (26) and Technical (TC) Component
PB15-61 Claims Processing Guidance for Implementing ICD-10 Codes
PB15-60 Eligible Clients under the Affordable Care Act Part IV (Temporary ID Update)
PB15-59 Audiology and Speech and Language Pathology Reimbursements
PB15-58 Pharmacy Legislative Changes and Prior Authorization Changes
PB15-57 Modifications to Prior Authorization Requirements for Select Surgical Codes
PB15-56 Important - Withdrawal of Home Health Aide Services Policy
PB15-55 Upcoming Changes to the Automated Voice Response System Menu Options
PB15-54 Elimination of Mailing Paper Remittance Advices
PB15-52 Billing Protocol for Services Provided in Emergency Rooms by Physicians Not Enrolled in Medicaid
PB15-51 Changes to the Orthodontic Qualifying Score
PB15-50 Payment Error Rate Measurement (PERM) Program Audit Requests
PB15-49 Important Changes to Electronic Orders for MEDS Products
PB15-48 Quantity Modifications for Laboratory Procedure Codes
PB15-47 Fee Schedule Updates for ICD-10 Diagnosis Codes
PB15-47 ICD-10 Related Explanation of Benefit (EOB) Codes in Connecticut Medical Assistance Program (CMAP)
PB15-46 Connecticut State Budget and Changes under the Connecticut Medical Assistance Program
PB15-45 Billing Procedures for Services Ordered by Residents and Interns
PB15-44 Continuation of the HUSKY Health Primary Care Increased Payments Policy
PB15-43 Changes to Submission Requirement for Home Health Services

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HP Enterprise Services
Box 2991
Hartford, CT 06104
www.ctdssmap.com