interChange Provider Important Message

Hospital Monthly Important Message Updated as of 02/12/2019

*all red text is new for 02/12/2019

CMAP Addendum B Reprocessing

DXC Technology identified outpatient and outpatient crossover claims with dates of services between January 1, 2017 to February 28, 2017 and January 1, 2018 to February 27, 2018 that processed incorrectly for “NEW” procedure codes as identified on the Connecticut Medical Assistance Program (CMAP) Addendum B and were not re-processed in the October 12, 2018 claim cycle. DXC Technology re-processed these claims in the December 21, 2018 claim cycle. These claims appeared on the December 26, 2018 Remittance Advice with an Internal Control Number (ICN) beginning with region code 52.

DXC Technology identified and adjusted all outpatient and outpatient crossover claims impacted by Ambulatory Payment Classification (APC) weight changes effective October 1, 2018. Outpatient claims with dates of services between October 1, 2018 to November 13, 2018 that were processed at the wrong APC weight were adjusted and the claims appeared on the January 23, 2019 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with a region code 52.

CMAP Addendum B January 2019

The Department of Social Services (DSS) will be updating the CMAP Addendum B to incorporate the 2019 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) for dates of service January 1, 2019 and forward to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system with a January 1, 2019 effective date on January 4, 2019. DXC Technology has determined there were no outpatient claims with date of services January 1, 2019 that processed with the incorrect payment rate.

For dates of service January 1, 2019 and forward the outlier dollar threshold has increased from $4,150.00 to $4,825.00.

Any other procedure code adds, changes or deletes with an effective date of January 1, 2019 and forward is tentatively scheduled to be updated on Wednesday February 27, 2019.

DRG Calculator - Updated January 4, 2019

The DRG calculator was updated and has been added to Hospital Modernization Web page for inpatient discharges January 1, 2019 and forward. APR-DRG Base Rate and Cost to Charge Rate were updated under the Provider table tab effective for discharges January 1, 2019 and forward.

Historical DRG calculators can be found under “DRG Calculator Historical Versions”.

DRG Weight, Average Length of Stay (ALOS) and Outlier Threshold Amount Updated 10/1/2018

- 02/12/2019 - Any inpatient claims with a discharge date of October 1, 2018 and forward that processed at the incorrect DRG weight or outlier amount will be identified and reprocessed in a future claim cycle yet to be determined (TBD).

interChange Provider Important Message

<u>Outstanding Questions</u>

Newborn DRG codes 5891 - 5894

- 2/12/2019 – DSS is currently reviewing DRG weights, ALOS and Outlier for DRG codes 5891-5894. Once this review is completed, the hospital important message will be updated.

Spinraza (Nusinersen) now Rebateable for HUSKY B Clients

- 01/08/2019 – The Department of Social Services has approved Spinraza (Nusinersen) for HUSKY B clients and the system was updated to allow HCPC code J2326 billed with National Drug Code (NDC) 64406005801 for HUSKY B clients on outpatient claims.

Outpatient Therapy Claims

- 01/08/2019 – Outpatient therapy claims that require Prior Authorization (PA) were taking the incorrect number of units on the authorization which could cause therapy services to be denied. The system was updated on December 11, 2018 to correct this issue and take the correct number of units on the authorization for therapy outpatient claims.

DXC Technology identified and re-processed outpatient therapy claims that were processed incorrectly that used the incorrect number of units from the therapy prior authorization. Outpatient therapy claims that took the incorrect number of units from the client's prior authorization were adjusted and the prior authorization was corrected. The adjusted outpatient claims appeared on your January 8, 2019 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

- Outpatient therapy claims were paying over the flat fee rate when billing multiple therapy codes on an outpatient claim paying under the HUSKY Plus Plan. The system was updated November 13, 2018 to correct this issue and allow up to the flat fee rate over multiple details.

DXC Technology identified an issue with outpatient therapy claims that paid over the therapy flat rate for clients covered under the HUSKY Plus Benefit plan. Outpatient therapy claims with Revenue Center Codes (RCCs) 421, 423, 424, 431, 433, 434, 441, 443 and 444 that paid more than the flat rate under the HUSKY Plus benefit plan were adjusted and appeared on your January 8, 2019 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

<u>Provider Manual Chapter 8 "Hospital" Updated</u>

Provider manual chapter 8 was updated to include revenue center codes 423 and 433 under Physical and Occupational Therapy and revenue center code 443 under Speech Therapy. In addition the following procedure codes were added to chapter 10: procedure 90791 with modifier U5, 97158, 96121, 96130-96133, and Neuropsychological testing codes 96136 and 96137 with modifier TF under behavioral health codes.

<u>Update to Outpatient Hospital Prior Authorization Grid</u>

Effective for dates of service January 1, 2019 and forward, hospitals are required to obtain prior authorization (PA) for procedure code Q2040 – Tisagenlecleucel, up to 600 million car-positive viable T cell, including leukapheresis and dose preparation procedures, per therapeutic dose.

Prior authorization is required for new procedure codes 77046 – 77047, C8903, C8905 – C8906 and C8908.

HUSKY PLUS Benefit Plan

HUSKY Plus provides supplemental coverage of goods and services for eligible HUSKY B members under the age of 19 years old who have intensive physical health needs and have exhausted one or more of their benefits covered under the HUSKY B plan. When eligibility changes and the client no longer has HUSKY Plus benefit plan and the hospital received a therapy Prior Authorization (PA) under their HUSKY Plus benefit plan, they will be required to get an updated PA for the HUSKY B benefit plan.

Provider Bulletins

Provider Bulletin 2018-82 "2019 Fee Schedule HIPAA Compliant Update For Autism Spectrum Disorder Services."

Effective for dates of service January 1, 2019 and forward, providers must use the following new CPT codes referenced below, when submitting claims for ASD services.

End Dated CPT Code	Description	New CPT Code
0359T	Comprehensive Diagnostic Evaluation (3-5hrs)	90791-U5
0359T-22	Expanded Comprehensive Diagnostic Evaluation (more than 5hrs)	90791-U5-22
0359T-52	Reduced Comprehensive Diagnostic Evaluation (less than 3hrs)	90791-U5-52
0372T	ASD Treatment Services- Group Setting	97158

Modifier U5 – Autism Services.

Provider Bulletin 2018-79 "Increasing the Reimbursement Rates for Selected Long-Acting Reversible Contraceptive Device."

The Department of Social Services (DSS) updated the reimbursement rate for Liletta, a Long-Acting Reversible Contraceptive Device (LARC). Effective for dates of service January 1, 2019 and forward, DSS is increasing the reimbursement rate for Liletta on the physician office and outpatient fee schedule to $684.38.

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 fee schedule.

For 340B hospitals, the family planning clinic fee schedule did not change.

Reminders:

Explanation of Benefits (EOB) Code 861 "NDC is missing or invalid"

Cause - NDC submitted on the claim meets one of the following criteria:

- The NDC is terminated on or after the claim date of service.
- The NDC is not Rebateable on the claim's date of service.
- The NDC is on the Drug Efficacy Study Implementation (DESI) list on the claim's date of service.
- The NDC is an institutional product.
- The NDC is repackaged or an inner package.
- The NDC is not active on the Drug file.

Resolution

interChange Provider Important Message

If the NDC was entered correctly, the drug product is not payable.

To determine the correct NDC associated to the drug related procedure code, go to www.ctdssmap.com → Provider → Drug Search, enter the procedure code then hit search.

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.

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

- Greenwich Hospital – Outpatient Hospital – 03/26/2019

TPL Audit Report - February 2019

The Third Party Audit reports were sent to the following hospitals on Monday February 4, 2019:

Gaylord Hospital, Prospect Manchester Hospital, Hartford Hospital, The Hospital of Central Connecticut, William W Backus Hospital and Yale New Haven Hospital.

HOLIDAY CLOSURE

The Department of Social Services (DSS) and DXC Technology will be closed on Monday, February 18, 2019 in observance of the Presidents' Day Holiday. DSS and DXC Technology offices will re-open on Tuesday, February 19, 2019.