interChange Provider Important Message

Hospital Monthly Important Message Updated as of 05/10/2017

*all red text is new for 05/10/2017

The following documents were recently updated:

CMAP Addendum B
The Department of Social Services (DSS) 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 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 future claim cycle.

Payment rate changes for the January 1, 2017 updates were adjusted in the 2nd cycle of April and appeared on your April 25th Remittance Advice.

The April version of CMAP Addendum B was post to the Web on April 13th and updated in the system on April 25, 2017. DXC Technology will re-process any impacted claims in a future claim cycle.

Hospital Refresher Workshops Completed

The presentation from the hospital refresher workshop is available on www.ctdssmap.com Web site under the Hospital Modernization page under "Provider Training" on the right side of the page.

Provider Manual Chapter 12 Update

Updates included: 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 2017-13 – Changes to the Radiology Authorization Date Span

Effective April 1, 2017 and forward, radiology authorizations for HUSKY Health Program members will be valid for sixty (60) days from the date of receipt. This is a change from the current authorization time span of thirty (30) days. Extensions beyond sixty (60) days will not be allowed. If the authorized study is not completed within the sixty (60) day time frame, providers will need to submit a new authorization request to eviCore and provide information supporting the medical necessity of the requested study.

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.

This will impact claims processing and the hospitals' ability to verify eligibility until the re-enrollment has been completed.

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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.

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.

- 5/10/2017 – 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.

- Procedure code C9483 was updated to allow up to 120 units January 1, 2017.

Outstanding Questions

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.

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.

- 4/1/207 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.

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Outpatient Surgery Claims Requiring Physician Prior Authorization.

- 4/1/2017 – DSS removed the PA requirement for outpatient surgical claims requiring a physician PA EOB code 3013 "Service requires a professional prior authorization" being on file for dates of service July 1, 2016 and forward. Hospitals can re-submit their claims for processing; no ID & reprocessing will be done by DXC.

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.

Radiology Prior Authorization (EviCore)

- 4/1/2017 – Either the ordering provider or facility may contact eviCore to request an authorization modification. Providers have up to 180 days to request a modification to an existing authorization. Because this is not a change in the actual study, just a change from a 70,000 code to a "C" code, this should not be subject to a new medical necessity review.

HUSKY Health Web Site Changes

www.huskyhealth.com is no longer a valid URL. This has changed to www.ct.gov/husky. If a provider clicks on the old Web site, they will receive a page cannot be displayed message. Hospitals should bookmark www.ct.gov/husky for future use.

National Drug Code billing

- 5/10/2017 – 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 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.

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Reduced/Discounted services

- 5/10/2017 - 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.

Claim Reprocessing

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 updated to be billed as the primary diagnosis which will bypass PA on a delivery inpatient stay:

O11.4, O11.5, O13.4, O14.04, O14.14, O14.24, O14.94, O16.4, O22.33, O34.32, O34.513, O34.83, O36.5931 – O36.5939, O36.8120, O36.8130, 036.8930, O40.9XX0 – O40.9XX3, O44.23, O44.33, O99.214.

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 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".

Reminder:

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.

HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) and DXC Technology will be closed on Monday, May 29, 2017 in observance of the Memorial Day Holiday. DSS and DXC Technology will re-open on Tuesday, May 30, 2017.