interChange Provider Important Message

Hospital Monthly Important Message Updated as of 02/8/2017

*all red text is new for 02/8/2017

Hospital Modernization

Hospitals can refer to the Hospital Modernization Web page on the www.ctdssmap.com Web site for information pertaining to the APR-DRG or APC. Please continue to send all APR-DRG or APC related questions to Hewlett Packard Enterprise at the following e-mail address: ctxixhosppay@hpe.com.

The following documents were recently updated:

- **DRG Calculator Updated January 11, 2017**

A second link has been added to Hospital Modernization Web page for inpatient discharges January 1, 2017 and forward. This includes updates to the DRG and Provider Tables effective for January 1, 2017.

- **CMAP Addendum B**

The Department of Social Services (DSS) is updating the Connecticut Medical Assistance Program's (CMAP's) Addendum B effective for dates of service January 1, 2017 and forward. A follow up important message will be sent once the addendum is updated and posted.

Any procedure code adds, changes or deletes that are effective for January 1, 2017 will be re-processed in a future claim cycle.

For dates of service January 1, 2017 and forward, the wage index, outlier threshold and the cost to charge ratios used in the outlier calculations will be updated. The outlier dollar threshold will increase from $2900.00 to $3825.00 for dates of service January 1, 2017 and forward.

The annual update will also include the addition of two new status indicators (SI) "E1" and "E2". The addition of the two new status indicators is replacing the former SI "E" for non-covered services.

Provider Bulletin 2016-99 – 2017 Annual Update – Outpatient Hospitals

1) **2017 Annual Update – CMAP's Addendum B**
2) **JW Modifier - Effective January 1, 2017**

Effective January 1, 2017, the Department will mirror Medicare by requiring the JW modifier for claims with unused single-use drugs or biologicals. When a provider must discard the remainder of a single-use vial or other single-use package after administering a dose of the drug or biological, the Department will reimburse for the amount of drug/biological that was administered, as well as discarded with the use of the JW modifier.

Billing Guidelines

For example, a single use vial that is labeled to contain 100 units of a drug has 95 units administered to a HUSKY Health member with 5 units discarded. The 95 units are billed on one detail line, while the discarded 5 units are billed on a separate detail line with the JW modifier. Both details will process for payment.

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3) Coding Changes

Mammography

Effective for dates of service January 1, 2017 and forward, the CPT coding for screening and diagnostic mammography is changing. Instead of billing for the computer aided detection (CAD) services as a separate add-on code, CAD will be included in the description for the screening and diagnostic mammography codes. Although the CPT codes are changing, there will be no change in reimbursement for the new mammography codes.

Physical and Occupational Therapy

Effective for dates of service January 1, 2017 and forward, the existing CPT codes for physical therapy (PT) and occupational therapy (OT) evaluations and re-evaluations will be replaced. The existing codes will be replaced by new codes that identify the level of complexity and specificity with regards to the patient's history and clinical presentation, as well as the level of decision making required by the provider. Although the CPT codes are changing, there will be no change in reimbursement.

Provider Bulletin 2016-88 – 2017 Coverage for Kyleena – intrauterine Device (IUD)

Effective November 1, 2016, the Department of Social Services is adding coverage for Kyleena, Long-Acting Reversible Contraceptive (LARC) device that became available in the marketplace October 10, 2016. Coverage for Kyleena is available under HUSKY A, B, C, D and the Family Planning – Limited Benefit (FAMPL) programs.

Until a unique Healthcare Common Procedure Coding System (HCPCS) code is assigned, outpatient hospitals should submit for reimbursement of Kyleena by billing with an applicable Revenue Center Code (RCC), HCPCS code C9399-Unclassified Drugs or Biologicals and the National Drug Code (NDC) for Kyleena. Claims submitted by hospitals for Kyleena will be reimbursed $858.33.

Inpatient Stays Following Observation/Outpatient Services

In response to inquiries from hospital providers and in order to clarify billing requirements, provider bulletin 2016-69 was to notify inpatient hospitals of the billing requirements for their inpatient stays following an outpatient or observation service for dates of service July 1, 2016 and forward.

- 2/2/2017 - The System was updated on January 24, 2017 and any claims that denied for EOB 0671 "DRG Covered/Non-Covered Days Disagree with the Statement Period" can be re-submitted for processing.

Medically Unlikely Edit (MUE) EOB 770 "MUE Units Exceeded"

The Department of Social Services (DSS) is reviewing procedure code's units against Medicare's units.

Procedure code C9473 was updated to allow up to 100 units January 12, 2017.

Procedure code J9228 was updated to allow up to 100 units January 18, 2017.

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Procedure code 88313 was updated to 8 units, 93798 was updated to 2 units, J0202 was updated to 12 units and J2930 was updated to 25 units on February 2, 2017 for dates of service 7/1/2016 and forward.

Procedure code P9016 was updated to 12 units for dates of service 10/1/2016 and forward.

If the hospital feels there are additional procedure codes in question, the procedure code and ICN of the claim can be sent to ctxixhosppay@hpe.com.

- 2/2/2017 – Hospitals are wondering how to appeal to allow great 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. DSS would like to follow the normal process for any reviews and the request will need to be sent to the Department through Hewlett Packard Enterprise Written Correspondence @ PO Box 2991 Hartford, CT 06014. The claim must have a cover letter explaining your request and medical documentation to justify the request.

Re-enrollment for Residents

Hewlett Packard Enterprise will begin to send out re-enrollment notification letters to resident providers starting January 1, 2017. Residents with a residency period greater than three years who are reaching the end of their enrollment period will be required to re-enroll. The notification letter will be sent 6 months prior to your re-enrollment due date. The re-enrollment letter will contain the Application Tracking Number (ATN) and provider ID required to access the reenrollment application via the online Re-enrollment Web Wizard, and will include instructions on how to re-enroll. Residents whose residency ends prior to their re-enrollment date, do not need to re-enroll.

If the residency period is continuing after the re-enrollment due date it is imperative that providers successfully complete the re-enrollment application as quickly as possible upon receipt of their notice. Residents with re-enrollment applications that are not fully completed by the residents' re-enrollment due date will receive a notice advising they have been dis-enrolled from the Connecticut Medical Assistance Program (CMAP).

Outstanding Questions

Flu Vaccine Availability and the Connecticut Vaccine program – Flucelvax (CPT code 90674)

2/2/2017 - This will following procedure code will be paid based on the fee schedule and will no longer be packaged effective for dates of service January 1, 2017 and forward. Procedure codes 90632, 90634, 90636, 90658, 90690, 90691, 90702, and 90717. DSS will add these codes to CMAP Addendum B once the new version is posted to the Web site.

- **Inpatient Hospital REHAB claims**

Inpatient DRG claims are denying for PA when the claim has a Medical DRG, but the hospital received a REHAB per-diem PA from CHN. Hewlett Packard Enterprise had reviewed these inpatient claim denials with DSS. The Department has agreed that these claims should consider the rehab prior authorization and pay at the per diem amount.

- 2/2/2017 - Hewlett Packard Enterprise has scheduled the system update for February 28, 2017 to allow claims to be considered for payment and the inpatient claims will be re-processed in the first cycle in March.

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Inpatient Only Procedures

DSS has made changes to some procedure codes on CMAP's Addendum B that were considered an inpatient only procedure. Previously, these services had a payment type of "NO" and were not covered in the outpatient setting. DSS has agreed that some of these procedures can be performed in an outpatient setting and these procedures will now show on the CMAP Addendum B with a payment type of SURG "Surgical procedures manually priced" and a payment rate of MP "Manual Priced".

Currently these services will continue to deny with Explanation of Benefit (EOB) 304 "APC – Services Considered an Inpatient Procedure" until there is a system update to suspend these outpatient claims with EOB code 6000 "Claim was Manually Priced or Denied for Missing Information" for DSS to manually price the procedure code and release for payment.

- 2/2/2017 - The System update is tentatively scheduled for February 28, 2017. Hewlett Packard Enterprise will re-process these claims in a future claim cycle.

Please be aware these services can still be performed as inpatient as long as it meets the inpatient Level of Care (LOC) and receive Prior Authorization (PA).

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 Hewlett Packard Enterprise believes 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: Hewlett Packard Enterprise 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. Hewlett Packard Enterprise 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.

- 2/2/2017 - Hewlett Packard Enterprise verified there was no increase in the amount 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 Hewlett Packard Enterprise and DSS are reviewing the trauma criteria for these letters to be sent.

Inpatient Hospital APR DRG Issue

As of November 30, 2016, Hewlett Packard Enterprise updated their system to process inpatient stays with admission date October 1, 2016 and forward using Version 34 of All Patient Refined-Diagnostic Related Group (APR DRG). Hewlett Packard Enterprise has identified an issue with inpatient claims that are priced by Version 34 of APR DRG tying to a DRG code not in

interChange. These inpatient claims were suspending with Explanation of Benefits (EOB) code 0675 "Provider DRG Code Not Found" or 0676 "DRG Code Weight Rate Not Found."

This also occurred on inpatient claims that were admitted prior to October 1, 2016, but are discharged on or after October 1, 2016. The inpatient claims that overlap October 1, 2016 denied for EOB code 0693 "Invalid Principal Diagnosis" and EOB code 0920 - "3M Grouper Error."

As of Tuesday December 13, 2016, Hewlett Packard Enterprise updated their system to process inpatient stays with discharge date October 1, 2016 and forward using Version 34 of All Patient Refined-Diagnostic Related Group (APR DRG).

The impacted claims were identified and reprocessed and appeared on your December 28, 2016 Remittance Advice (RA) with Internal Control Number (ICN) beginning with region code 27.

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.

Hospitals cannot balance bill if the client is dually eligible (Medicare plan and HUSKY plan) for Medicare and Medicaid for services not covered by Medicare and they can refer to Medicare Learning Network (MLN) Matters number SE1128 "Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program" for specific guidelines.

Claim Reprocessing

No Physician Prior Authorization on File

Hewlett Packard Enterprise has identified and denied outpatient claims that originally processed without a physician Prior Authorization (PA) on file. The impacted outpatient paid claims were identified and denied with Explanation of Benefits (EOB) code 3013 "Service Requires a Professional Prior Authorization" and appeared on the January 10, 2017 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

Outpatient claims with procedure code 41899 that denied with EOB 3013 was reviewed by DSS and they have agreed that this procedure will no longer require a physician prior authorization. The system was updated and the claims were re-processed and appeared on the January 10, 2017 RA.

Medicare HMO lab crossover claims not considering the Medicare HMO co-pay.

- 2/2/2017- Hewlett Packard Enterprise previously identified Medicare HMO laboratory crossover claims that were not considering the Medicare HMO co-pay. Hewlett Packard Enterprise has identified additional claims that should have previously been re-processed retroactive to January 1, 2014. The additional claims have been reprocessed and will appear on your February 7, 2017 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with a region code 15 if originally paper, or a region code 27 if originally electronic.

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HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) will be closed on Monday, February 13, 2017 in observance of Lincoln's Birthday. In addition, DSS and Hewlett Packard Enterprise will be closed on Monday, February 20, 2017 in observance of the Presidents' Day holiday. Both DSS and Hewlett Packard Enterprise offices will re-open on Tuesday, February 21, 2017.

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