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Hospital Monthly Important Message Updated as of 09/14/2016

*all red text is new for 09/14/2016

Hospital Modernization - Ambulatory Payment Classification (APC)

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

The following documents were recently updated:

- **Provider Manual Chapter 8 - Updated 08/23/2016**

Updated as a result of Hospital Modernization initiative.

- **CMAP Addendum B - Updated 9/6/2016**

The updated PDF and Excel CMAP Addendum B for the 2nd Quarter has been approved by the Department and added to the hospital modernization page on the www.ctdssmap.com Web site. These changes will be effective for date of service July 1, 2016 and forward. We have also posted a new PDF document titled "CMAP Addendum B Changes" to the hospital modernization page. This will also highlight what was new, deleted or changed (*) on the CMAP Addendum B for July 1, 2016. There is a new tab on the excel version of the CMAP Addendum B called "Changes-Aug2016". This will also highlight what was new, deleted or changed (*) on the CMAP Addendum B for July 1, 2016.

Hewlett Packard Enterprise will be performing an ID and re-process for claims that would process differently based on the updates to Addendum B for dates of service July 1, 2016 and forward in a future cycle.

Hospital Web Claim Submission Workshops:

HPMyRoom Virtual Classroom Training:

Friday September 16, 2016 10 AM – 12 PM

Tuesday September 20, 2016 10 AM – 12 PM

The topics include:

- Web Claim Submission
- Clerk Maintenance
- Eligibility Verification
- Web Claim Inquiry
- Web Claim Submission
- Web Claim Adjustment
- Hospital Billing Changes
- Training Wrap up and Questions

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Provider Bulletin 2016-52 - Phase II - Changes to the Children's Dental Fee Schedule for September 1, 2016

The purpose of this policy transmittal is to notify dental providers that, effective for dates of service September 1, 2016 and forward, there will be a 2% reduction for the rate of reimbursement to the children's dental fee schedule. The selective dental services identified in provider bulletin PB 2016-45 will not be affected by the 2% reduction. There will be no change to the adult dental fee schedule reimbursement rate.

The dental fee schedule will now be split into two (2) dental fee schedules. The fee schedules will be separated by the reimbursement rates for adults and children.

Provider Bulletin 2016-50 - Eligible Clients under the Affordable Care Act Part V (Temporary ID Notice Update)

The purpose of this provider bulletin is to provide an update to the information regarding temporary client IDs as well as a reminder for billing and prior authorization guidelines to providers rendering services to individuals determined to be eligible through Access Health CT (AHCT). This bulletin supersedes all previously published provider notifications (PB14-01, PB14-15, PB14- 29, PB14-31 and PB15-60).

Providers may continue to contact Hewlett Packard Enterprise to have a temporary client ID issued in the event that an individual presenting an AHCT "Application Results" eligibility notice does not have an eligible client ID in the Automated Eligibility Verification System (AEVS) or the Secure Web portal.

Provider Bulletin 2016-47 – New Autism Spectrum Disorder Services

Effective for dates of service on and after July 1, 2016, there will be several Autism Spectrum Disorder (ASD) Services available for members under the age of 21 and for whom these services have been determined to be medically necessary. All services referenced below require prior authorization from the behavioral health Administrative Services Organization, Beacon Health Options. All of the changes described below apply to services provided on dates of service on and after July 1, 2016.
Outpatient Hospital Clinics: ASD services must be billed with the applicable HCPC/CPT and RCC combination. Hospitals will be reimbursed using the Clinic and Outpatient Hospital Behavioral Health Fee Schedule. In order to receive reimbursement, RCC 919 must be used in conjunction with the applicable ASD procedure code. To determine reimbursement for the above noted ASD services, use the newly assigned rate type of "OMH".

Outstanding Questions

Inpatient Admissions Following Outpatient or Emergency Department Services

Inpatient claims are denying with EOB codes 0671 "DRG Covered/Non-covered Days Disagree with the Statement Period" and 0672 "DRG Accommodation Days Inconsistent with the Header Date Period" for inpatient admissions following outpatient or emergency department services. Also some claims are denying with EOB code 529 "Surgical Procedure Date is prior to Admission Date."

- 08/01/2016 - The Department and Hewlett Packard Enterprise made updates to the system on August 1, 2016 to EOB 671 to allow these claims to be considered for

payment. Claims that previously denied for this issue can be re-submitted for processing.

- 09/01/2016 - ID and Reprocess of denied claims will be scheduled for a future cycle once system updates are completed.

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

- 9/1/2016 - DSS has agreed to re-process hospital's denied claims going back to January 1, 2014 claims to be re-processed in a special cycle target date October 2016.

- 9/1/2016 - The Department has agreed that these claims should consider the co-pay amount / co-insurance amounts and is working on updates to the system to allow claims to be considered for payment. Target date is Sept 27, 2016.

Transgender gender clients and the eligibility process.

The hospital was asking who they can contact to provide updates to the client's eligibility in these cases and if they can bill with condition code 45 "Ambiguous Gender Category" to override claims that deny due to gender not matching.

- DSS states hospitals can contact the DSS benefits center, but any eligibility updates could require the client to provide this informational change.

- 9/01/2016 - The Department and Hewlett Packard Enterprise are still working on system updates to allow these claims to be considered for payment. Target date is Sept 27, 2016.

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.

- 8/01/2016 - The Department has agreed that these claims should consider the rehab prior authorization and pay at the per diem amount and Hewlett Packard Enterprise is working on updates to the system to allow claims to be considered for payment. Target date is October 1, 2016.

Prior Authorization for Rehabilitation (Physical, Occupational and Speech Therapies)

If the hospitals previously received a Prior Authorization (PA) from Community Health Network of CT (CHNCT) for outpatient rehabilitation that overlaps July 1, 2016 the hospital will need to bill with the Revenue Center Code (RCC) they were authorization for. For example: If the hospital received a PA for RCC 420 (Physical Therapy), the hospital would need to continue to bill with RCC 420 until the authorization is expired, even though it was previously published that RCC 420 can only be submitted on crossover claims. For PAs granted after July 1, 2016 CHNCT will only be authorization for the accepted therapies RCCs for dates of service July 1, 2016 and forward.

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Outpatient Prospective Payment System and Inpatient Only Procedures

The Department of Social Services (DSS) has become aware that there may be some procedures on CMAP's Addendum B that are designated as an inpatient only procedure, for which the hospital has previously performed in the outpatient hospital setting. The Department is requesting that hospitals review CMAP's Addendum B; particularly those codes assigned a status indicator of "C" – Inpatient only procedure, procedure not paid under OPPS. 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@hpe.com.

Outpatient Hospital Behavioral Health Prior Authorization Issue

Behavioral health services with dates of service in June 2016 or June spanning into July 2016 that were previously suspended with Explanation of Benefit (EOB) code 3003 "Prior Authorization is Required for Payment of this Service" was re-processed in the September 9. 2016 claim cycle. . If there is a PA on file, the claim will process using the PA. If there is no PA on file the claim will deny for EOB code 3003. In addition, all behavioral health claims with dates of service July 1, 2016 and forward that forced to pay with EOB code 3003 were adjusted. If there is a PA on file the claim was re-processed using the PA. If there is no PA on file, the claim would have been denied with EOB code 3003. These Behavioral health claims appear on the September 13, 2016 Remittance Advice (RA).

There are Husky A claims that denied for EOB 3003 that will be processed in the next cycle.

Updates to 835 Electronic Remittance Advice (ERA)

The following are Claim Adjustment Reason Code (CARC) and/or Remittance Advice Remark Code (RARC) changes that were requested by the hospital will impact the 835 ERAs beginning September 14, 2016 and forward.

CARC	RARC	EOB	EOB Description	Change to BS	Change to CARC	Change to RARC
16	N657	0309	APC-Only incidental services reported	4	234	N676
16	N657	0311	APC -Implanted device w/o implantation procedure or administered substance w/o associated procedure	3	B15	M51
16	N657	0314	APC-Observation revenue code on line item with non-observation HCPCS code	Same	199	N657
188	N386	0323	APC-Service provided prior to date of National Coverage Determination (NCD) approval	Same	50	N386
16	N657	0332	Incorrect billing of revenue code with HCPCS code	Same	199	N657
16	M51	0333	APC-Claim lacks required primary code	3	B15	M51
22	N598	2504	Bill Private Carrier First or Invalid Adjustment Reason Code Billede	Same	22	N36

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The Connecticut Medical Assistance Program Explanation of Benefits (EOB) Crosswalk is available on the Web site www.ctdssmap.com. To access this crosswalk from the Home page, select "Publications", scroll down to "Claims Processing Information" and then select "CT Medical Assistance Program EOB Crosswalk – Pharmacy and Non-Pharmacy".

Physical, Occupational and Speech Therapies

Hewlett Packard Enterprise noticed two issues with outpatient therapy claims paying incorrectly for dates of service July 1, 2016 and forward. Outpatient physical, occupational or speech therapy claims that were processed prior to September 1, 2016 were either paying more than 1 visit per day or some therapy services were denied due to a prior authorization issue.

Claims that were previously overpaid or denied with Explanation of Benefit (EOB) code 6401 "PA Required for More than 2 PT visits per week" will be re-processed by Hewlett Packard Enterprise in a future claim cycle.

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.

The following units were updated on the following codes.
96361 increased to 24 units
P9040 increased to 8 units
G0277 increased to 5 units
59025 increased to 2 units
96375 increased to 5 units
G0277 increased to 4 units

If the hospital feels there are additional procedure code in questioned those procedure code, including the ICN of the claim can be sent to ctxixhosppay@hpe.com for review.

Discounting Factors

Hewlett Packard Enterprise noticed an issue with the discounting factor causing outpatient surgery claims to process differently than expected. Hewlett Packard Enterprise updated their system on September 7, 2016 and previous claims can be adjusted to process correctly.

Hewlett Packard Enterprise will re-process any outpatient claims that were processed incorrectly in a future claim cycle.

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