interChange Provider Important Message

Hospital Monthly Important Message Updated as of 08/15/2018

*all red text is new for 08/15/2018

The following documents were recently updated:

CMAP Addendum B July 1, 2018

The updated version of the CMAP Addendum B and NEW procedure codes were updated on July 24, 2018 with an effective date of July 1, 2018 and forward.

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system prior to July 1, 2018. Any claims that are submitted for dates of service July 1, 2018 and forward that have a status indicator of G or K will process at the correct payment rate.

CMAP Addendum B Reprocessing Timeline

CMAP Addendum B Version	Effective Date	Updated	Adjustment Dates	Tentative Target Date
V17.2	July 1, 2016	September 28, 2016	July 1, 2016 – September 27, 2016	**TBD**
V17.3	October 1, 2016	November 30, 2016	October 1, 2016 to November 29, 2016	**TBD**
V18.0	January 1, 2017	March 1, 2017	January 1, 2017 to February 28, 2017	**TBD**
V19.0	January 1, 2018	February 28, 2018	January 1, 2018 to February 27, 2018	**TBD**
V19.1	April 1, 2018	May 10, 2018	N/A	
V19.2	July 1, 2018	July 24, 2018	N/A	

DXC Technology will be adjusting claims with APC weight changes, status indicator changes, and other change indicated by an "X" in the change field on the CMAP.

DXC Technology will be identifying and reprocessing outpatient claims that processed incorrectly for "NEW" procedure codes in a future claim cycle.

Outstanding Questions

Advanced Beneficiary Notice (ABN) Forms

- 6/1/2018 - Hospital claim denied for Explanation of Benefit (EOB) code 2502 "Bill Medicare First." The hospital has an Advanced Beneficiary Notice (ABN) form and in this case is not billing Medicare first. At this time there are only posted instructions for home health providers when there is an ABN form and there are no specific instructions for hospitals to follow. Changes in processing guidelines may have implications beyond hospitals so DSS and DXC Technology are still reviewing billing guidelines for all providers including hospitals.

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Reminders / Updates

Provider Bulletin 2018-48 - Clarifying the Discontinuation of a Non-surgical, Permanent Birth Control Device as a Covered Benefit of the HUSKY Health Program

As previously communicated in PB 2018-26, effective July 1, 2018, the Department of Social Services (DSS) no longer covers non-surgical, non-hormonal implanted birth control devices or any similar devices under the HUSKY Health program.

Current Procedure Terminology (CPT) code 58565 - Hysteroscopy sterilization was end-dated for dates of service, July 1, 2018 and forward was changed to a "No" under the payment type column on the Connecticut Medical Assistance Program Addendum B for outpatient hospitals.

Provider Bulletin 2018-43 - Removal of Authorization/Registration for Behavioral Health Professional Services Rendered in an Emergency Department

Effective for dates of service July 1, 2018 and forward, prior authorization (PA)/registration will no longer be required for behavioral health professional services when rendered in Place of Service (POS)/Facility Type Code (FTC) 23 – Emergency Department (ED).

Although PA/registration will be removed in POS/FTC 23 (ED) – hospitals should be in contact, at least daily, with the Department of Social Services Behavioral Health (BH) Administrative Services Organization – Beacon Health Options regarding the status of patients waiting for a BH placement at an alternate facility that provides behavioral health services.

Consistent with Sec. 17b-262-971(c) (1) (2) of the Regulations of Connecticut State Agencies Concerning Outpatient Hospital Services, physicians (including psychiatrists, advanced practice registered nurses (APRNs) including psychiatric APRNs, psychologists and behavioral health clinicians such as licensed clinical social workers and licensed professional counselors) can bill for and be separately reimbursed for medically necessary BH services rendered in POS/FTC 23 (ED). The procedure codes billed must be on the applicable provider's fee schedule and within the practitioner's scope of practice.

As a reminder outpatient hospital BH services are considered an all-inclusive rate and professional fees will not be reimbursed separately for medically necessary services rendered in POS/FTC 19 (off campus-outpatient hospital) or 22 (on campus-outpatient hospital).

Provider Bulletin 2018-39 - Diagnostic Related Group (DRG) Coding Reviews

In the next few months, the Department of Social Services (DSS) will begin conducting reviews of inpatient hospital claims paid under a Diagnostic Related Group (DRG) methodology to ensure DSS is reimbursing the proper amount for these claims in conformance with Medicaid and DSS policy. These post payment reviews will be conducted by DSS's contractor, Health Management Systems, Inc. (HMS).

Additional information and instructions will be provided to the hospitals by HMS at the beginning of the review process. If you have any questions about the information in this bulletin, please contact CT_Medicaid_State@hms.com.

Provider Bulletin 2018-31 - Revised Medicaid (HUSKY) Spend-down Procedures

The Department of Social Services (DSS) made some changes to the way it processes Medicaid (HUSKY) "spend-down" cases. DSS has updated the address and form used to submit HUSKY spend-down medical expenses.

Hospitals with questions can call the HUSKY Spend-down Processing Center Monday through Friday, from 8:30 am to 5:00 pm at 1-877-858-7012.

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Effective immediately, hospitals should now send medical expenses submitted on behalf of spenddown clients to:
DSS ConneCT Scanning Center
P.O. Box 1320
Manchester, CT 06045-1320

ASC X12N Health Care Eligibility/Benefit Inquiry and Information Response (270/271)

- 8/1/2018 - DXC has completed updating the ASC X12N Health Care Eligibility response file 270/271 to allow eligibility searches based on date of birth and name, and not require a social security number. Please refer to the updated companion guide for 270/271 transactions under the www.ctdssmap.com Web site under trading partner select EDI and scroll down to the link titled: 201 / 271 Companion Guide for additional information.

Timely Filing for Behavioral Health Services for HUSKY A and B

Effective for claims received July 1, 2018 all behavioral health services provided to individuals eligible for HUSKY A and B will have a timely filing requirement of one (1) year. This will include conditions that override timely filing such as times, but not limited to; when Medicaid is secondary providers will have one (1) year from the issue date on the other insurance payment or denial, providing the other insurance denial was not for timely filing.

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:

- Hospital Of Special Care – Dental Outpatient Hospital Clinic – 09/10/2018
- Yale New Haven Hospital – Rehab Inpatient Hospital – 09/28/2018

HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) and DXC Technology will be closed on Monday, September 3, 2018 in observance of the Labor Day holiday. Both the DSS and DXC Technology offices will re-open on Tuesday, September 4, 2018.