interChange Provider Important Message

Hospital Monthly Important Message Updated as of 01/10/2018

*all red text is new for 01/10/2018

The following documents were recently updated:

DRG Calculator Updated January 2, 2018

The DRG calculator was updated and was added to Hospital Modernization Web page for inpatient discharges January 1, 2018 and forward. This includes an update to the Provider Table CT tab effective for January 1, 2018. Historical DRG calculators will be under "DRG Calculator Historical Versions".

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, 2018 and forward.

Procedure codes with a payment rate change effective for January 1, 2018 and forward will not be loaded until after January 1, 2018. Any claims processed prior to the new payment rates being loaded will be systemically adjusted, tentatively scheduled for the 2nd cycle in January.

Once the CMAP Addendum B is updated a follow up important message will be posted and sent to the hospitals.

For dates of service January 1, 2018 and forward the outlier dollar threshold has increased from $3825.00 to $4,150.00.

Provider Bulletin 2017-93 - Announcement of Non-Emergency Medical Transportation (NEMT) Contractor

Effective for dates of service January 1, 2018 and forward, Non-Emergency Medical Transportation (NEMT) for Medicaid members will be coordinated through a new contractor, Veyo, a Total Transit company. Additional information may be found at: http://portal.ct.gov/DSS/Health-And-Home-Care/Non-Emergency-Medical-Transportation.

Provider Bulletin 2017-71 – Nusinersen Coverage Guidelines – Revised to include a Prior Authorization Process for Outpatient Hospitals

Effective November 1, 2017 and forward, outpatient hospitals buying and billing for Spinraza must utilize a separate PA process identified below. Outpatient hospitals must fax a completed Spinraza PA Request Form along with the required documentation to Community Health Network of CT, Inc. (CHNCT) at (203) 265-3994.

The Spinraza PA Request Form for outpatient hospitals is available on the HUSKY Health Web site at: www.ct.gov/husky. To access the form, click on For Providers, followed by Prior Authorization Forms and Manuals under the Prior Authorization menu item.

For questions regarding the PA process for outpatient hospitals, please contact CHNCT at 1-800-440-5071.

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Closed Questions / Issues

Inpatient Behavioral Health Claims

DXC Technology previously identified an issue with inpatient behavioral health claims incorrectly reimbursing the entire claim when there were not enough Prior Authorization (PA) units to cover the entire inpatient stay. The impacted claims were identified and reprocessed and appeared on the September 12, 2017 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52. The inpatient claims were adjusted to pay the correct number of days per the Prior Authorization (PA) on file.

If the hospital received 2 PAs from Beacon Health Options for the one inpatient admission, the claim was reprocessed only using 1 PA on file. The reprocessed inpatient claim only had one room and board detail on the claim thereby not using all the units from both PAs, causing the claim to cut-back the reimbursement. DXC Technology worked with the hospitals to correct the claims and re-submitted them in the December 8, 2017 claims cycle.

3M Grouper

Inpatient claims with From and Through Dates of Service overlapping October 1, 2017 that were submitted with a new ICD-10 surgical procedure code effective October 1, 2017 with a date prior to October 1, 2017 will deny with EOB code 4067 "Non-Covered ICD Procedure Code". DXC Technology system was updated on December 12, 2017 and the hospitals can re-submit their claims.

Outstanding Questions

Outpatient Therapies Claims

- 1/1/2018 - The hospitals have requested DXC Technology to review outpatient therapies claims not reimbursing up to the flat rate due to the first detail billing less than the contract rate and the second detail denying as a duplicate. DXC has reviewed the outpatient claims and is working on system updates.

CMAP Addendum B January 2017

- 1/1/2018 - The date of the special cycle will be announced in the near future and the hospital monthly important message will be updated at that time for dates of services January 1, 2017 to March 1, 2017.

Explanation of Benefits (EOB) code 5008 "Duplicate of a Paid Claim or a Claim that is Currently in Process"

- 1/1/2018 - DXC has identified an issue when there is an inpatient claim and the client is discharged from the hospital, but the client returned to the hospital on the same day, but the claim is not admitted until the next day which is causing the second inpatient claim to deny as a duplicate. The EOB code is tentatively scheduled to be updated on January 23, 2018 and at that time the hospital can re-submit their inpatient claims for processing.

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Reminders / Updates

Medically Unlikely Edits Review Process

The Department of Social Services (DSS) has received claims to review that exceeded the National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) limit, but have not received any additional information that will support a determination that the service for which payment denied was medically necessary.

Hospital can request DSS review of claims with denied details due to exceeding an MUE with Explanation of Benefits (EOB) Code 770 "MUE Units Exceeded" per Provider Bulletin 2017-69 "National Correct Coding Initiative (NCCI) – Medically Unlikely Edits Review Process".

If a service denies solely due to exceeding the NCCI MUE limit, providers may submit a request to have the service reviewed. The detail that exceeded the allowed MUE must be broken out into two separate details. The first detail line should be submitted with the allowed MUE units and the remaining units must be submitted on a separate detail with modifier GD "Unit of Service > MUE Value". The claim should be submitted as an electronic claim and it will suspended for review with Explanation of Benefit (EOB) code 772 "Unit of Service > MUE and Claim Paid/Denied after policy review". If the original claim was partially paid it should be voided and the claim should be re-submitted electronically.

The electronic claim must be submitted following the guidelines set forth in Provider Bulletin 2017-49, "Electronic Claim Submission with Paper Attachment Process" for an MUE review.

The additional information can be faxed to 1-860-986-7995 or mailed to DXC Technology, PO Box 2971 Hartford, CT 06104 following the instructions for submitting paper attachments in Provider Bulletin 2017-49.

Electronic claims submitted for review will remain in a suspended status for 30 calendar days, if additional information is not received by 30 calendar days the service will be denied.

Coding Changes for Eteplirsen and Nusinersen

Effective for dates of service January 1, 2018 and forward, the coding for Eteplirsen, marketed as Exondys 51 is changing. The existing procedure code C9484 will be end dated on 12/31/2017 and will be replaced with J1428 "Injection Eteplirsen, 10mg" effective 1/01/2018.

Effective for dates of service January 1, 2018 and forward the coding for Nusinersen, marketed as Spinraza™ is changing. The existing procedure code C9489 will be end dated on 12/31/2017 and will be replaced with J2326 "Injection, Nusinersen, 0.1mg" effective 1/01/2018.

Due to the delay in receiving the CMS Addendum B files and the inability to update the claims processing system by January 1, 2018, claims submitted with the new procedure codes will deny. Hospitals may either hold claims until the system is updated or if they submit claims with the new procedure code, the procedure will deny until the system is updated. Once the system is update the hospitals will be able to adjust/re-submit their claim for processing.

Provider Manual Chapter 8 Hospital - Updated 12/12/2017

Added the following:

- Hospital readmissions on the Same Date of Service submission requirements.
- Link to the 2018 Present on Admission (POA) Codes exempt list.
- Procedure code 96125 under Speech Therapy RCC effective for July 1, 2016.

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Request for Assistance in Obtaining Payment when a Primary Carrier Fails to Pay or Respond to the Provider's Claim.

- In cases where the primary insurance to Medicaid is denying the claim due to not receiving information from the client, the hospital can submit the TPL claim denials to Medicaid for processing with the appropriate Claim Adjustment Reason Code (CARC) 227 and Remittance Advice Reason Code (RARC) N179. The hospitals should continue to try to receive payment from the primary carrier and once they receive it, any previously submitted claims should be adjusted.

- In cases where the primary insurance to Medicaid is not responding to the claim due to not receiving information from the client, the hospital should use the Legal Notice of Subrogation Form (W-81) when initially pursuing commercial health insurance. This puts the insurance company on legal notice that it must make any payment for which it is liable for directly to the provider.

- If the hospital does not receive payment within forty-five days, they should fully document that every reasonable attempt was made. The provider must file a request for assistance with the Connecticut Department of Insurance using form W-82, Request for Assistance in Obtaining Payments. Department of Insurance will furnish the hospital with a file/case number.

- DSS is aware that other insurance carriers never cover some services. In addition, there are some insurance companies that do not provide an actual denial statement or, in some cases, never respond to written requests. To address these problems and to alleviate any unnecessary burden on the provider, DSS implemented the Third Party Billing Attempt, (W-1417). This form documents that the hospital has made every attempt to obtain payment from the other insurance carrier prior to claim submission to the Connecticut Medical Assistance Program. The form may be used in place of a denial voucher for the other insurance carrier, but may not be used in place of a Medicare denial. If the provider has not received any insurance payment within ninety days of the date of the initial claims submission, then the provider may bill the Connecticut Medical Assistance Program. The Department of Insurance file number is required on the W-1417 form. Failure to include the Department of Insurance file number will result in the claim being returned to the provider.

These instructions can be found under Provider Manual Chapter 5 "Claim Submission Information" on the www.ctdssmap.com Web site under the hospital modernization page, by clicking on Provider Manuals on the right side of the page. The forms can be downloaded from the www.ctdssmap.com Web site, under Information and then Publications and scrolling down to Third Party Liability Forms.

For any additional questions, the hospitals can contact the TPL unit at DSS.

Step by Step Tool to determine the DRG code

Hospitals can download the hospital refresher workshop on www.ctdssmap.com Web site under the Hospital Modernization page under "Provider Training" on the right side of the page for step by step instructions on using the 3M Health Information System to determine the DRG code.

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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 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.

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

- Hospital for Special Care Outpatient – 01/24/2018
- St Vincent Medical Center Inpatient – 01/29/2018
- Stamford Hospital Inpatient Rehab Unit – 02/20/2018

HOLIDAY CLOSURE: Please be advised, DSS and DXC Technology will be closed on Monday, January 15, 2017 in observance of the Martin Luther King Jr.'s Day Holiday. DSS and DXC Technology offices will re-open on Tuesday, January 16, 2018.