interChange Provider Important Message

Hospital Monthly Important Message Updated as of 11/13/2018

*all red text is new for 11/13/2018

CMAP Addendum B Reprocessing Completed

DXC Technology performed a special claim cycle on October 12, 2018 to adjust all outpatient and outpatient crossover claims impacted by Ambulatory Payment Classification (APC) weight changes, status indicator changes, and other changes indicated by an "X" in the change field on the CMAP Addendum B. Outpatient claims with dates of services between July 1, 2016 to September 27, 2016, October 1, 2016 to November 29, 2016, January 1, 2017 to February 28, 2017 and January 1, 2018 to February 27, 2018 that were processed incorrectly were adjusted in the special claim cycle and the claims appeared on the October 16, 2018 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with a region code 55.

DXC Technology also identified any outpatient and outpatient crossover claims that processed incorrectly for "NEW" procedure codes and re-processed the claims in the October 12, 2018 claim cycle. These claims appeared on the October 16, 2018 RA with an ICN beginning with a region code 61 or 27.

CMAP Addendum B - October 2018

An updated PDF and Excel version of Connecticut Medical Assistance Program (CMAP) Addendum B has been approved by the Department of Social Services (DSS) and was added to the Hospital Modernization page on the www.ctdssmap.com Web site. These changes are effective for dates of service October 1, 2018 and forward.

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system with an October 1, 2018 effective date. Any claim with a status indicator of G or K for dates of service October 1, 2018 and forward have been reimbursed the updated rate.

We have posted the October changes to the CMAP Addendum B Changes document on the Hospital Modernization page under "CMAP Addendum B Changes and Historical Versions".

The changes can be identified by the following indicators:

- "X" – A change has been made to the procedure code or payment rate (status indicator G or K).
- "New" – The procedure code was added by CMS

Older versions of CMAP Addendum B can be found under the Hospital Modernization page under "CMAP Addendum B Changes and Historical Versions."

Any other procedure codes that were added, change or deleted with an effective date of October 1, 2018 and forward is scheduled to be updated on November 13, 2018.

3M DRG Grouper

The System to start processing using APR-DRG V36 is scheduled to be updated on November 13, 2018. Prior to the update of the ICD-10 (International Statistical Classification of Diseases) diagnosis codes and surgical procedure codes, inpatient DRG claims with header Through Date Of Service (TDOS) October 1, 2018 and forward were being suspended with either Explanation of Benefit (EOB) code 0693 "Invalid Principal Diagnosis" or EOB code 0920 "3M Grouper Error." These claims are tentatively scheduled to be released for processing in the November 23, 2018 claim cycle.

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DRG Calculator - Updated November 13, 2018

The DRG calculator was updated and has been added to Hospital Modernization Web page for inpatient discharges October 1, 2018 and forward. DRG weights, ALOS and outlier threshold amounts were updated under the DRG tables tab effective for October 1, 2018.

Any inpatient claims with a discharge date October 1, 2018 and forward that processed at the incorrect DRG weight or outlier amount will be identified and reprocessed in a future claim cycle TBD.

Outstanding Questions

Advanced Beneficiary Notice (ABN) Forms

- 11/1/2018 - 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.

  Per DSS the hospitals will need to bill Medicare first and receive a denial. The hospitals cannot follow the ABN instructions for home health agencies. DXC has escalated the hospital's concern back to DSS for review.

  11/13/2018 – Per DSS the hospital will need to continue to receive the Medicare denial.

Spinraza (Nusinersen) not Rebateable for HUSKY B Clients

- 11/1/2018 - The Department of Social Services is working with the manufacturer to see about participating in the drug rebate for HUSKY B.

Outpatient Therapy Claims

- 11/1/2018 – Outpatient therapy evaluation claims were not paying up to the flat fee rate when multiple details were being billed for a single date of service when the charges on the first detail was less than the contract rate. The system was updated on September 5, 2018 to correct this issue and allow the flat rate to pay over multiple details.

- Outpatient therapy claims that require Prior Authorization (PA) were taking the incorrect number of units on the authorization which could cause therapy services to be denied. DXC is working on correcting the system and the important message will be updated once the system is updated.

- Outpatient therapy claims were paying over the flat fee rate when billing multiple therapy codes on an outpatient claim paying under the HUSKY Plus Plan. The system is scheduled to be updated November 13, 2018 to correct this issue and allow up to the flat fee rate over multiple details.

Any outpatient therapy claims that processed incorrectly will be identified and reprocessed in a future claim cycle TBD.

Inpatient Claims Allowing Over DRG Amount

DXC Technology has identified and reprocessed any inpatient claims that overpaid due to a change in the client's benefit plan during an inpatient stay that caused the inpatient claim to pay at an incorrect prorated amount. The issue has been corrected and DXC Technology has identified and reprocessed these claims to pay at the correct DRG amount in the November 9, 2018 claims processing cycle. The

reprocessed claims will appear on your November 14, 2018 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 50.

Notification of Newborn Form W-416

Hospital can sent their Notification of Newborn Forms W-416 to ExpeditedHusky.DSS@ct.gov.

Reminders

Status Indicator G "Drug Biological Pass Through" and K "Non-Pass-Through Drugs and Biologicals"

If the procedure codes payment type is APC-PR with a status indicator of G or K, it will be reimbursed based on the payment rate on CMAP Addendum B x the number of units up to the detail billed charges. We will pay the lesser of billed charges and the payment rate. We only allow more than the detail amount when the claims process at an APC rate.

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

The Department of Social Services (DSS) started 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. If you have any specific questions to the findings in the audit you can call 1-866-206-6855.

Explanation of Benefit (EOB) Code 4127 - Benefit Plan Hierarchy is not Found, Contact the Provider Assistance Center

Cause - The client's eligibility changed during the inpatient or outpatient crossover claim and is requiring the claim to be split into two claims so it doesn't overlap the change.

Resolution - Perform a client eligibility verification transaction to determine the client's eligibility during the stay and split the claim accordingly. If the hospital cannot determine how to split the claim, the hospital may contact the DXC Provider Assistance Center (PAC) for assistance.

Inpatient delivery stays denying due to lack of prior authorization when the delivery stays do not require prior authorization

Previous inpatient delivery stays that were denied, 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".

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.

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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 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:

- The Connecticut Hospice – Acute Inpatient Hospital – 12/6/2018
- Norwalk Hospital – Dental Outpatient Clinic – 12/19/2018

HOLIDAY CLOSURE

The Department of Social Services (DSS) and DXC Technology will be closed on Thursday, November 22, 2018 in observance of Thanksgiving. DXC Technology's office will also be closed on Friday, November 23, 2018 in observance of Thanksgiving. DSS will be open on Friday, November 23, 2018.