interChange Provider Important Message

Hospital Monthly Important Message Updated as of 08/17/2016

*all red text is new for 08/17/2016

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 07/01/2016**
  As of July 1, 2016 hospital should no longer be billed with RCC 423 "Physical Therapy Group", RCC 433 "Occupational Therapy Group" and RCC 443 "Speech Therapy Group". However, these RCCs will still be accepted from Medicare on a Medicare crossover claim.
- **Hospital Outpatient Fee Schedule - Updated 07/01/2016**
- **Outpatient Hospital Modernization FAQ - Updated 06/21/2016**

  Q. Previously the hospitals were billing procedure code 99211 – 99245 in connection to RCC 51X "Clinic". Per addendum B these codes are no longer covered by CT Medicaid. What procedure code should the hospitals use for their clinic services?

  A. Procedure code G0463 "Hospital outpt clinic visit" should be billed with clinic RCCs when performed in the hospital's outpatient clinic. Failure to bill with G0463 will result in the service being denied with Explanation of Benefit (EOB) code 896 "Procedure not billable with RCC."

Scheduled Hospital Refresher Workshops:

Connecticut Hospital Association, 110 Barnes Road, Wallingford, CT
Friday August 19, 2016 1:00 PM – 4:00 PM

HPMyRoom Virtual Classroom Training
Tuesday August 23, 2016 9:00 AM – 12:00PM

The topics include:

- Demographic Maintenance
- Clerk Maintenance
- Web Claim Submission Overview
- Web Claim Submission Benefits
- Web Claim Inquiry
- Web Claim Submission
- Hospital Billing Changes
- CMAP Addendum B
- Frequent Claim Denial
- Inpatient Transfer DRG Claim
- Training Wrap up and Questions

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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

Provider Bulletin 2016-35 – Outpatient Hospital Modernization – Behavioral Health Services

Effective for dates of services July 1, 2016 and forward, outpatient hospital BH services will be reimbursed either by:

1. Fixed fee based on revenue center code (RCC) and Healthcare Common Procedure Code System (HCPCS) combination ; or

2. HCPCS/Current Procedural Terminology (CPT) based on a fee schedule.

Outpatient hospital Behavioral Health (BH) services will be modernized under OPPS, but will be carved out of the Ambulatory Payment Classification (APC) methodology. OPPS logic will take precedence over any previous provider bulletins; hospitals should follow CMAP's Addendum B and the new outpatient hospital regulation. Effective for dates of service July 1, 2016 and forward, the following BH related provider bulletins and policy transmittals will be rescinded for outpatient hospitals:

PB 2016-02 - Billing for Partial Payment for Behavioral Health Intermediate Level of Care
PB 2014-32- Partial Day Billing for Behavioral Health Intermediate Levels of Care
PB 2013-11 - RCC Crosswalk to New Psychiatric Procedure Codes for 2013
PB 2012-01 - Transition from Revenue Center Code 513 to More Precise Coding for Hospital Outpatient Psychiatric Services

Provider Bulletin 2016-34 – Guidelines for Observation for Medical and Behavioral Health Services

Effective for dates of services on and after July 1, 2016, the Connecticut Medical Assistance Program (CMAP) will model Medicare's coverage policy related to observation services as outlined in Medicare's Claim Processing Manual Chapter 4 –Part B Hospital (Including Inpatient Hospital Part B and OPPS posted at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf. This change coincides with the implementation of the Outpatient Prospective Payment System (OPPS) and includes behavioral health observation services. As of July 1, 2016, this bulletin supersedes Provider Bulletin 2011-46 Clarification of Observation Guidelines.

When an observation stay results in an inpatient admission, prior authorization from the appropriate entity is required. The date of the inpatient admission will be the date of the inpatient order. Observation services that result in an inpatient admission to the same hospital shall not be reimbursed separately. Observation services will be rolled into the inpatient admission. Please refer to PB 2015-82 "Three Day Rule: Outpatient Stay Prior to Inpatient

Admission" for more information on services that will not pay if billed within three (3) days of an inpatient admission.

Provider Bulletin 2016-31 – Elimination of Paper Claims Notification

The purpose of this provider bulletin is to notify all providers that effective October 1, 2016, the Department of Social Services (DSS) will no longer accept paper claims for processing. The Department is mandating this change as a means to provide a more streamlined and cost effective method for reimbursement for the Connecticut Medical Assistance Program. Providers are encouraged to check with their claim vendors in order to begin preparing for this transition by ensuring that all claims are submitted to Hewlett Packard Enterprise electronically, using the ASC X12N 837 Health Care Claim or through the Provider Secure Web Portal at www.ctdssmap.com.

Provider Bulletin 2016-25 – Update Regarding Outpatient Hospital Modernization - Outpatient Prospective Payment System (OPPS)

In accordance with section 17b-239 of the Connecticut General Statutes, as amended, the Department of Social Services (DSS) is modernizing outpatient hospital reimbursement under the Connecticut Medical Assistance Program (CMAP) from the current model to an Outpatient Prospective Payment System (OPPS) similar to Medicare. CMAP OPPS utilizes both revenue center codes (RCC) and procedure code information to determine reimbursement levels. Specifically, procedure code information will enable the complexity of the service performed to influence its level of reimbursement.

The draft regulations can be accessed via the Department of Social Services Web site. Go to www.ct.gov/dss, and then select "Publications," then "Policies and Regulations," then "Notices of Intent, Operational Policies, and Proposed Regulations," and then "Regulations Concerning Outpatient Hospital Services."

The regulation will also be posted to the **www.ctdssmap.com** Web site. To access the regulation, go to "Information", then "Publications", then "Provider Manuals Chapter 7", and then choose "Hospital Outpatient" from the drop down menu.

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.
- 08/01/2016 - ID and Reprocess of denied claims will be scheduled for a future cycle once system updates are completed.

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

- 8/1/2016 - DSS has agreed to re-process hospital's denied claims going back to January 1, 2014.

- 04/26/2016 - 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 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.

- 08/01/2016 - The Department and Hewlett Packard Enterprise are still working on system updates to allow these claims to be considered for payment. Target date October 1, 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.

- 08/01/2016 - 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.

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 is 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

Hewlett Packard Enterprise has been notified of a Prior Authorization (PA) issue with hospital outpatient behavioral health services that require PA. These outpatient behavioral health services with dates of service July 1, 2016 and forward were previously suspending with Explanation of Benefit (EOB) code 3003 "Prior Authorization is Required for Payment of this Service" will be re-processed and if there is a PA is on file, the claim will process using the PA on file. If the PA has not been loaded by Beacon Options then these claims will be released and forced to pay in the August 5, 2016 claim cycle. These Behavioral Health Claims will appear on the August 9, 2016 Remittance Advice (RA). Once all the behavioral PAs are correctly loaded into the system, the behavioral health outpatient claims will be re-processed in a future cycle

Please note, there is a small subset of behavioral health outpatient claims with dates of service in June or in June and spanning into July will continue to suspend with EOB code 3003 "Prior Authorization is Required for Payment of this Service" until the PA issue is corrected.

Non-behavioral health services that were suspending with EOB code 3003 will be released and denied with EOB code 3003, if there is no PA on file from CHN.

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

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".

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