interChange Provider Important Message

Hospital Monthly Important Message Updated as of 03/8/2017

*all red text is new for 03/8/2017

Hospital Modernization

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

The following documents were recently updated:

- **CMAP Addendum B**

The Department of Social Services (DSS) updated the Connecticut Medical Assistance Program's (CMAP's) Addendum B effective for dates of service January 1, 2017 and forward.

Any procedure code adds, changes or deletes with an effective date of January 1, 2017 was updated in the system on March 1, 2017. Hewlett Packard Enterprise will re-process any impacted claims in a future claim cycle.

Provider Bulletin 2017-08 – Changes to the Prior Authorization Process for Genetic Testing Services

Effective April 1, 2017, all HUSKY Health medical policies currently in use by Community Health Network of Connecticut, Inc. (CHNCT) to review requests for genetic testing services will be retired. McKesson's InterQual Molecular Diagnostics Criteria will instead be used, in conjunction with the Department of Social Services' (DSS) definition of medical necessity (see section 17b-259b of the Connecticut General Statutes). The Criteria provides evidence-based clinical decision support for molecular and genetic tests.

Re-enrollment for Hospital

The hospitals are reminded to watch their re-enrollment due date with Medicaid. Hospitals will be sent a re-enrollment notification letter six (6) months prior to their re-enrollment and we encourages the hospital to enroll as soon as possible. Failure to complete the re-enrollment process **by the re-enrollment due date** will be dis-enrolled the hospital on the enrollment due date and no claims after that date will be processed 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.

Medically Unlikely Edit (MUE) EOB 770 "MUE Units Exceeded"

The Department of Social Services (DSS) is reviewing procedure codes units against Medicare's units.

Procedure code 90376 was updated to allow up to 20 units and procedure code 86665 was updated to allow up to 2 units on February 16, 2017 for dates of service October 1, 2016.

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Procedure code J7185 was updated to allow up to 4000 units, procedure code 85397 was updated to allow up to 3 units on February 24, 2017 76825 for dates of service October 1, 2016 and procedure code 76825 was updated to allow 3 units for dates of service July 1, 2016.

These claims will need to be re-submitted by the hospitals as they are currently not part of the monthly mass adjustments updates that are done.

If the hospital feels there are additional procedure codes in question, the procedure code and ICN of the claim can be sent to ctxixhosppay@hpe.com.

- 3/1/2017 – Hospitals are inquiring how best to request a review of when to allow greater than MUE units. The hospitals are not questioning the MUE units set in the system. This would be a specific claim they would like reviewed to allow additional units. DSS would like to follow the normal process for any reviews and the request will need to be sent to the Department through Hewlett Packard Enterprise Written Correspondence at PO Box 2991 Hartford, CT 06104. The claim must have a cover letter explaining your request and medical documentation to justify the request. A provider bulletin is currently being drafted to document the review and billing procedure hospitals should follow.

Outstanding Questions

Flu Vaccine Availability and the Connecticut Vaccine program – Flucelvax (CPT code 90674)

2/2/2017 - This will following procedure code will be paid based on the fee schedule and will no longer be packaged effective for dates of service January 1, 2017 and forward. Procedure codes 90632, 90634, 90636, 90658, 90690, 90691, 90702, and 90717. DSS will add these codes to CMAP Addendum B once the new version is posted to the Web site.

Inpatient Hospital REHAB claims

Inpatient DRG claims are denying for prior authorization (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. The Department has agreed that these claims should consider the rehab prior authorization and pay at the per diem amount.

- 3/1/2017 - Hewlett Packard Enterprise system was updated and inpatient REHAB claims can be re-submitted for processing. The hospital can re-submit any claim that is within timely for processing or wait for the ID and re-process of these claims by Hewlett Packard Enterprise in the first cycle in March.

Inpatient Only Procedures

DSS has made changes to some procedure codes on CMAP's Addendum B that were considered an inpatient only procedure. Previously, these services had a payment type of "NO" and were not covered in the outpatient setting. DSS has agreed that some of these procedures can be performed in an outpatient setting and these procedures will now show on the CMAP Addendum B with a payment type of SURG "Surgical procedures manually priced" and a payment rate of MP "Manual Priced".

- 3/1/2017 - The System was update on February 28, 2017 to suspend these outpatient claims with EOB code 6000 "Claim was Manually Priced or Denied for Missing Information" for DSS to manually price the procedure code and release for payment.

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The hospital can re-submit their claims to be manually priced or wait for the ID & process of these claims by Hewlett Packard Enterprise in a future claim cycle.

Emergency Department Accident Related Request Forms

Hospitals are receiving a high number of Emergency Department Trauma related request forms looking for additional documentation. The hospitals are looking for a person at DSS to discuss why there are so many requests.

In April 2016 this process was automated and now the letters are generated and sent to providers systematically. This means that the volume that a hospital used to receive over a longer period of time (say a few months) is now being sent at one time since manual intervention is no longer needed. The Department and Hewlett Packard Enterprise believe that the same volume is being sent to each hospital, but that it feels different to the hospital because the time span in which that volume is received has been significantly shortened.

As an additional note: Hewlett Packard Enterprise has in the past reviewed the diagnosis codes flagged as part of the trauma criteria to remove codes that really are not trauma/accident related (i.e. bee stings), but they will once again review to ensure that they have captured and removed everything that clearly does not make sense. Hewlett Packard Enterprise said that now that the process is systematic they will have the ability to "track" the volume of letters generated and sent to the hospitals to see if there is indeed a spike moving forward. There was no spike in the volume of letters being sent. The volume has been steady each month.

- 3/1/2017 - Hewlett Packard Enterprise verified there was no increase in the volume of letters being sent to the hospital due to new ICD-10 codes. The letters are only sent out once a month to the hospitals. Due to the high number of letters being sent to the hospitals each month Hewlett Packard Enterprise and DSS are reviewing the trauma criteria for these letters to be sent.

Medicare Covered Services Only – Qualified Medicare Beneficiary (QMB)

If the client is Qualified Medicare Beneficiary (QMB) Medicare Covered Services only, they can bill the client for non-covered services since Medicaid only considers the claim as secondary when there is a Medicare co-insurance and/or deductible amounts.

Hospitals cannot balance bill if the client is dually eligible (Medicare plan and HUSKY plan) for Medicare and Medicaid for services not covered by Medicare and they can refer to Medicare Learning Network (MLN) Matters number SE1128 "Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program" for specific guidelines.

Claim Reprocessing

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

Hewlett Packard Enterprise previously identified Medicare HMO laboratory crossover claims that were not considering the Medicare HMO co-pay. Hewlett Packard Enterprise has identified additional claims that should have previously been re-processed retroactive to January 1, 2014. The additional claims have been reprocessed and will appear on your February 7, 2017 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with a region code 15 if originally paper, or a region code 27 if originally electronic.

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

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. DSS has determined that there were ICD-10 diagnosis codes that should have bypassed the PA requirement on an inpatient delivery stay. The following diagnosis codes were updated to be billed as the primary diagnosis which will bypass PA on a delivery inpatient stay:

O11.4, O11.5, O13.4, O14.04, O14.14, O14.24, O14.94, O16.4, O22.33, O36.5931 – O36.5939, O36.8120, O36.8130, 036.8930, O40.9XX0 – O40.9XX3, O44.23, O44.33, O99.214.

If the hospital still believes there are other diagnoses that should be considered to bypass PA when a delivery occurs, please send claim examples (including ICN) to Hewlett Packard Enterprise at the following e-mail address: ctxixhosppay@hpe.com.

The following diagnosis code was requested by the hospitals, but was not added D58.2, D64.9, Z34.03, O10.013, O13.1, O24.415, O24.425, O26.86, O28.8, O30.009, O35.1XX0, O09.513, O09.523, O09.293 and O34.211, O98.513, O99.013, O99.213, O99.283, O99.323 and O99.333.

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