interChange Provider Important Message

Hospital Monthly Important Message Updated as of 09/11/2018

*all red text is new for 09/11/2018

The following documents were recently updated:

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

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

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

3M Grouper

Due to the update with the ICD-10 (International Statistical Classification of Diseases) code effective for October 1, 2018 this could cause inpatient DRG claims with header Through Date Of Service (TDOS) October 1, 2018 and forward to suspend with either Explanation of Benefit (EOB) code 0693 "Invalid Principal Diagnosis" or EOB code 0920 "3M Grouper Error" until the new 3M Grouper is loaded in October. Once the updated grouper version is loaded into the system the claims will be re-cycled for processing. An important message will be posted once the new grouper version has been scheduled to be loaded into the system.

Reminders / Updates

Provider Bulletin 2018-59 - Timely Filing Requirements for Behavioral Health Services

This bulletin serves to notify enrolled Connecticut Behavioral Health Partnership (CTBHP) providers, effective for claims received July 1, 2018 and forward, all behavioral health services provided to HUSKY Health members will have timely filing requirements 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 insurance denial was not for timely filing.

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Provider Bulletin 2018-54 - Elimination of Co-payments for Behavioral Health Services Rendered to HUSKY B Members under the Connecticut Medical Assistance Program (CMAP)

Effective for dates of service September 1, 2018 and forward, the co-payment requirement is discontinued for all behavioral health (BH) services rendered to HUSKY B members under the Connecticut Medical Assistance Program (CMAP). As long as the billed amount on the claim is greater than the allowed amount, providers are eligible to receive the full fee schedule amount.

There are no changes to the HUSKY B cost share requirements for medical and dental services. Providers must continue to collect the required cost-share for medical and dental services rendered to HUSKY B members.

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).

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.

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<u>Outstanding Questions</u>

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.

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 **<u>the re-enrollment due date</u>** 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

Inpatient Admission Not Authorized Due to Medical Necessity

If the hospital orders an inpatient admission and CHNCT does not authorize the prior authorization due to medical necessity, the hospital should bill according to the patient's status prior to the inpatient admission. If there was an observation order prior to the admission, the hospital should bill according to the observation guidelines. If the patient was not in observation prior to the inpatient order, the hospital should bill as outpatient. The hospital's documentation needs to support the hospitals billing of the service.

Qualified Medicare Beneficiaries (QMB) Remittance Advice (RA)

On December 8, 2017, CMS systems reverted back to the previous display of patient responsibility Claim Adjustment Reason Code (CARC) 1 "Deductible Amount" and CARC 2 "Co-Insurance Amount" for QMBs on the Medicare RA. I have recently received calls asking questioning how to bill Medicaid as secondary if they receive CARC 209 – "Per regulatory or other agreement" on their QMB RAs.

Reminder: The provider cannot collect this amount from the patients. However, this amount may be billed to subsequent payer. Hospitals should refund any amounts received from the patients.

The QMB RAs will include the revised Alert Remittance Advice Remark Codes RARCs N781 and N782 on the RA.

RARC N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.

RARC N782 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

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When billing Medicaid and other secondary insurers, RARC N781 equates to CARC 1 – Deductible Amount and RARC N782 equates to CARC 2 – Coinsurance Amount and hospitals should be using those CARCs when billing Medicaid as secondary. If a claim contains both RARC N781 and N782, this means the beneficiary deductible and coinsurance amounts have been combined, you must get a breakdown of these amounts prior to submitting to Medicaid.

Please refer to the following Centers for Medicare and Medicaid Services (CMS) document for additional information.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10433.pdf