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Hospital Monthly Important Message Updated as of 10/09/2018

*all red text is new for 10/09/2018

The following documents were recently updated:

CMAP Addendum B Reprocessing Timeline

CMAP Addendum B Version	Effective Date	Updated	Adjustment Dates	Target Date
V17.2	July 1, 2016	September 28, 2016	July 1, 2016 – September 27, 2016	**October 12**
V17.3	October 1, 2016	November 30, 2016	October 1, 2016 to November 29, 2016	**October 12**
V18.0	January 1, 2017	March 1, 2017	January 1, 2017 to February 28, 2017	**October 12**
V19.0	January 1, 2018	February 28, 2018	January 1, 2018 to February 27, 2018	**October 12**

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 the October 12, 2018 claim cycle.

The APC adjustments will be done in a special claim cycle to adjust all outpatient claims impacted by APC weight changes, status indicator changes, and other change indicated by an "X" or "NEW" in the change field on the CMAP Addendum B on October 12, 2018. Outpatient claims that were processed incorrectly will be adjusted in the special claim cycle and the claims will appear on the October 16, 2018 Remittance Advice.

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.

Any other procedure codes that were added, change or deleted with an effective date of October 1, 2018 and forward are tentatively scheduled to be updated in October.

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

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

Any questions on the updated version of the CMAP Addendum B should be sent to DXC Technology using the following e-mail address: ctxixhosppay@dxc.com.

3M Grouper

The update to the ICD-10 (International Statistical Classification of Diseases) codes effective October 1, 2018 may 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.

DRG Calculator - Updated October 8, 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 were updated under the DRG Tables tab effective for October 1, 2018.

Historical DRG calculators will be under the link called "DRG Calculator Historical Version".

Reminders / Updates

Provider Bulletin 2018-62 - Authorization for Palivizumab (Synagis®) - 2018-2019 Respiratory Syncytial Virus (RSV) Season

This bulletin provides important information to providers regarding the clinical and prior authorization (PA) requirements for palivizumab (Synagis®) for the 2018-2019 Respiratory Syncytial Virus (RSV) season. Synagis® is used as prophylaxis against RSV, the most common cause of bronchiolitis and pneumonia in young infants.

The Connecticut Department of Social Services (DSS) requires that hospitals that purchase and bill for Synagis® obtain PA. PA is not required when Synagis® is given as part of an inpatient admission. Outpatient hospitals must fax a completed PA request form along with supporting clinical information to Community Health Network of Connecticut, Inc. (CHNCT) at (203) 774-0549.

Outpatient hospitals should reference CMAP's Addendum B for reimbursement of procedure code 90378 – Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each.

Palivizumab (Synagis®) is not rebateable for HUSKY B clients.

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 2018-43 - 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).

Outstanding Questions

Advanced Beneficiary Notice (ABN) Forms

- 10/1/2018 - 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.

  Hospitals will need to bill Medicare first and receive a denial. The hospitals cannot follow the ABN instructions for home health agencies.

Spinraza (Nusinersen) not Rebateable for HUSKY B Clients

- 10/1/2018 - The department of Social Services is working with the manufacturer to see about participating in the drug rebate for HUSKY B.

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Outpatient Therapy Claims

- 10/1/2018 – 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) are taking the incorrect number of units on the authorization which could cause therapy services to be denied. DXC is working on correcting the system. The important message will be updated once the system is updated.

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.