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Hospital Monthly Important Message Updated as of 11/09/2016

*all red text is new for 11/09/2016

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:

- **CMAP Addendum B - Updated November 8, 2016**

The updated PDF and Excel CMAP Addendum B for October 1, 2016 has been approved by the Department and added to the hospital modernization page on the www.ctdssmap.com Web site. These changes will be effective for date of service October 1, 2016 and forward. We have also updated the PDF document titled "CMAP Addendum B Changes" on the hospital modernization page.

The changes can be identified by the following indicators:

- "N" - The procedure code was added by CMS,
- "D" - The procedure code was deleted by CMS,
- "*" - The procedure code was updated by CMS, and
- "DSS" - The procedure code was a DSS change only listed under the changed column.

- **Provider Manual Chapter 12 - Claim Resolution Guide**

Added cause and resolution of Explanation of Benefit (EOB) codes 4985 "Procedure restriction for RCC under provider contract" and 5025 APC duplicate claim – APC Service must be on same claim for date of service".

- **Outpatient Hospital Modernization FAQ updated 10/18/2016**

Provider Bulletin 2016-76 - Flu Vaccine Availability and the Connecticut Vaccine program - Flucelvax (CPT code 90674)

Under the Connecticut Vaccine Program (CVP), Flucelvax (Seqirus), identified with National Drug Code 70461-0614-01, will be supplied by the CT Department of Public Health (CT DPH) for use with patients 4 years of age and older. Common Procedural Terminology (CPT) code 90674 can be coded when the Flucelvax (Seqirus) vaccine is administered to eligible HUSKY Health members during the 2016-2017 flu season as part of the CVP eligibility criteria. The administration of the Flucelvax flu vaccine is eligible for reimbursement when the vaccine is administered as part of the CVP to eligible HUSKY Health members, ages 4 years to 18 years old.

Billing guidelines:

Flucelvax vaccine CPT code 90674 should be billed under Revenue Center Codes (RCC) 25X or 63X. Consistent with current policy, the detail line submitted for the Flucelvax vaccine CPT code 90674 will deny and the administration will be reimbursed under RCC 771 "Vaccine Administration" with CPT code 90460 according to the Medicaid Hospital Outpatient fee schedule.

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Provider Bulletin 2016-70 - Important Changes to the Radiology Benefit Management Program

Effective January 1, 2017 the HUSKY Health radiology benefit management program will be transitioned to eviCore healthcare (eviCore). eviCore will review prior authorization (PA) requests and render medical necessity determinations for non-emergent outpatient advanced imaging services scheduled for dates of service January 1, 2017 and forward. The existing radiology benefit management program that is currently administered by Care to Care will end as of December 31, 2016.

Effective January 1, 2017, when the following services are to be performed in an outpatient hospital setting, the ordering provider must request authorization using the corresponding Healthcare Common Procedure Coding System (HCPCS) "C" code instead of the Current Procedural Terminology (CPT) code. Hospitals should confirm that a valid, approved authorization is on file for the appropriate "C" code prior to performing the service.

Provider Bulletin 2016-69 - Billing Guidelines for Inpatient Stays Following Observation/Outpatient Services

In response to inquiries from hospital providers and in order to clarify billing requirements, this bulletin is to notify inpatient hospitals of the billing requirements for their inpatient stays following an outpatient or observation service for dates of service July 1, 2016 and forward.

Due to the update in policy some inpatient claims could deny with EOB 671 "DRG Covered/Non-covered Days Disagree with the Statement Period" until the Department and Hewlett Packard Enterprise make updates to allow these claims to be considered for payment. Once the system is updated the claims can be re-submitted for processing.

Provider Bulletin 2016-66 - Treatment for Gender Identity Disorder – Gender Reassignment Surgery and Procedures

This bulletin provides guidance to physicians and hospitals related to gender reassignment surgical procedures to treat gender dysphoria under the Connecticut Medical Assistance Program (CMAP) for eligible HUSKY Health members under HUSKY A, C and D. Coverage for gender reassignment surgical procedures and associated procedures that are deemed medically necessary to treat gender dysphoria became effective March 1, 2015 under CMAP.

Provider Bulletin 2016-65 - Procedure for Removal of Hospital Lock-In Status and Use of Medicaid Prescription Vouchers for Individuals Released from Correctional Institutions or Through the Courts

The purpose of this bulletin is to advise providers of the process for having a client's Hospital Lock-In status removed. This will allow prescription processing for otherwise Medicaid- eligible clients in suspension status.

The Department of Social Services' (DSS) Pre- Release Unit, not Health Information Designs, who handle the normal Pharmacy Lock-Ins, must be contacted by the provider when a Hospital Lock-In individual presents a prescription to be filled.

Provider Bulletin 2016-64 - Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health and CADAP Programs)

The Department of Social Services (DSS) and Hewlett Packard Enterprise has published the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA),

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Check and Electronic Funds Transfer (EFT) issue dates and 835 Schedule for Jan 2017 – June 2017 cycles.

APC Grouper Software

The Department has given 3M the green light to develop software for the hospitals. If the Hospitals are interested in 3M developing a CT version of the grouper, they should be contacting their 3M representative.

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

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

The following units were updated on the following codes on September 15, 2016. 96361 increased to 24 units, P9040 increased to 8 units, G0277 increased to 5 units, 59025 increased to 2 units, 96375 increased to 5 units, J9179 increase to 50 units, 77300 increase to 10 units, G0260 increase to 2 units, J9042 increase to 200 units, P9047 increase to 20 units, J9307 increase to 80 units, P9033 increase to 12 units.

The following units were updated on the following codes on October 6, 2016.
86666 increased to 4 units, C9132 increased to 5500 units, J1610 increased to 3 units, 86747 increased to 2 units.

The following units were updated on the following codes on October 12, 2016.
86160 increased to 4 units, 86235 increased to 10 units, J1610 increased to 3 units.

The following units were updated on the following codes on November 1, 2016.

82787 increased to 4 units
G0424 increased to 2 units

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.

Third party Liability (TPL) HMS Audits

- Health Management Systems (HMS) performs the Third Party Liability Medicaid recovery is federally required when client TPL is identified after Medicaid has paid for the individual's cost of care. Generally HMS accomplishes this work by submitting Medicaid claims directly to a health insurance company. However, Medicaid hospital claims often lack detail information necessary for insurance companies to successfully adjudicate them. Consequently, hospital claims are recovered through provider disallowance (recoupment). This results in the highest possible TPL recovery insuring Medicaid is payer of last resort. Provider disallowance is not a hospital audit and the Department does not advise HMS on the number of claims per hospital that should be selected. Rather, HMS selects claims based on its identification and verification of new health insurance, the re-verification of existing TPL information, and that the insurance coverage is in effect for the claim dates of service. Therefore, HMS will select a hospital claim containing a Claim Adjust Reason Code (CARC) indicating the client does not have health insurance coverage (e.g. CARC 27 - "Expenses incurred after coverage terminated"). HMS will soon be modifying its process to exclude a hospital claim that contains a CARC pertaining to health insurance cost sharing, i.e. copays, coinsurance, deductibles, or other reasons indicative of cost sharing. Health

insurance provider disallowance claim selection is performed every sixty (60) days. During calendar year 2015 HMS notified hospitals on six (6) occasions of Medicaid claims that should be billed to client health insurance. On each notification, a hospital received about twenty-six (26) claims with a Medicaid dollar value of $12K. We realize that sometimes a claim may be incorrectly selected. From notification, the hospital has a two-month window to provide information to HMS demonstrating why its Medicaid claims should not be recouped. Valid documentation will stop the provider disallowance from occurring.

- 11/01/2016 - The Department is verifying if HMS has modified the process.

Outstanding Questions

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.

- 11/01/2016 - 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 tentatively for December 2016.

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".

Currently these services will continue to deny with Explanation of Benefit (EOB) 304 "APC – Services Considered an Inpatient Procedure" until there is a system update 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.

- 11/1/2016 - A follow up Important Message will be sent once the system is updated to start suspending these outpatient claims to be manually priced by the Department.

Please be aware these services can still be performed as inpatient as long as it meets the inpatient Level of Care (LOC).

Outpatient Hospital Behavioral Health Prior Authorization Issue

- 11/1/2016 - Behavioral health services for date of service July 1, 2016 and forward that were previously suspended with Explanation of Benefit (EOB) code 3003 "Prior Authorization is required for Payment of this Service" and re-processed in the September 9. 2016 claim cycle were denied with EOB code 3003 even though there was a PA on file for the claim. The prior authorizations for these claims are currently being corrected by Beacon Options and once corrected these claims will be processed tentatively scheduled in the 2nd cycle in November.

- There are Husky A claims that denied for EOB code 3003 that is also tentatively schedule to be re-processed in the 2nd cycle in November.

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 believes 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.

- 11/01/2016 - The Department and Hewlett Packard Enterprise will check the volume to see if there was a spike and review the findings for possible additional changes.

Version 33 vs Version 34 of APR DRG Grouper Software

As of October 1, 2016, the International Statistical Classification of Diseases (ICD)-10 code set used to report medical and behavioral diagnoses, has been updated with a new ICD-10 diagnosis code set. Hewlett Packard Enterprise has identified an issue when the new ICD-10 diagnosis code is billed on inpatient stays causing the claim to deny with Explanation of Benefit (EOB) code 0693 - "Invalid Principal Diagnosis" and EOB code 0920 - "3M Grouper Error". Version 33 of APR DRG Grouper Software, that is currently being used, cannot price claims using the new ICD-10 codes. Hewlett Packard Enterprise is currently working on updating their system to process inpatient stays with admission date October 1, 2016 and forward using Version 34 of APR DRG to process claims.

Hewlett Packard Enterprise will update this important message once the system is updated and claims can be re-submitted for processing.

Special Claim Cycle – November 18, 2016

Discounting Factors

Hewlett Packard Enterprise noticed an issue with the discounting factor causing outpatient surgery claims to process differently than expected. Hewlett Packard Enterprise updated their system on September 7, 2016 and previous claims can be adjusted to process correctly. Hewlett will re-process any outpatient claims that were processed incorrectly in the special claim cycle in November and appear on your November 15, 2016 Remittance advice.

Physical, Occupational and Speech Therapies

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Hewlett Packard Enterprise noticed two issues with outpatient therapy claims paying incorrectly for dates of service July 1, 2016 and forward. Outpatient physical, occupational or speech therapy claims that were processed prior to September 1, 2016 were either paying more than 1 visit per day or some therapy services were denied due to a prior authorization issue.

Claims that were previously overpaid or denied with Explanation of Benefit (EOB) code 6401 "PA Required for More than 2 PT visits per week" will be re-processed by Hewlett Packard Enterprise in the special claim cycle in November and appear on your November 15, 2016 Remittance advice.

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

DSS has agreed to re-process the hospitals denied claims going back to January 1, 2014 claims. They will be re-processed in the special claim cycle in November and appear on your November 15, 2016 Remittance advice.

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