interChange Provider Important Message

Hospital Monthly Important Message Updated as of 10/11/2017

*all red text is new for 10/11/2017

The following documents were recently updated:

CMAP Addendum B

The date of the special cycle will be announced in the near future and the hospital monthly important message will be updated at that time.

The October version of CMAP Addendum B was posted to the www.ctdssmap.com Web site.

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system with an October 1, 2017 effective date. Any claim with a status indicator of G or K for dates of service October 1, 2017 and forward have been reimbursed the updated rate. Any other procedure code add, change or deletes with an effective date of October 1, 2017 and forward is tentatively scheduled to be updated in the system October 24, 2017.

3M Grouper

System updates for the 3M Grouper is tentatively scheduled for October 24, 2017. Due to the update with the ICD-10 (International Statistical Classification of Diseases) code set this could cause inpatient DRG claims with header Through Date Of Service (TDOS) October 1, 2017 and forward to suspend with either Explanation of Benefit (EOB) code 0693 "Invalid Principal Diagnosis" or EOB code 0920 "3M Grouper Error." 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 we know when the new grouper version will be loaded to the system.

Provider Bulletin 2017-58 - Provider Satisfaction Survey

The Department of Social Services is conducting a Provider Satisfaction Survey to obtain your feedback on the services provided by DXC Technology. Our goal is to consistently improve our service to you in all areas. Your comments on DXC Technology's performance as well as areas which still require attention are appreciated and will assist us in serving you better.

Provider Bulletin 2017-29 - Provider Audit Trainings

The Department of Social Services (DSS) is offering free training directed to Connecticut Medical Assistance Program (CMAP) providers in an effort to help them improve compliance with Medicaid requirements under state and federal laws, regulations and policies. This will be done through increased knowledge of audit preparation, the audit process, common errors found during an audit and a discussion of the audit protocols. To sign up for the provider audit training go to http://www.ctdss.net/osdevents/.

The hospital outpatient audit training is scheduled for November 15, 2017 at Connecticut Valley Hospital - Merritt Hall from 9 AM - 12 PM.

Closed Questions / Issues

Inpatient Behavioral Health Claims

DXC Technology previously identified an issue with inpatient behavioral health claims incorrectly reimbursing the entire claim when there were not enough Prior Authorization (PA)

units to cover the entire inpatient stay. The impacted claims were identified and reprocessed and appeared on the September 12, 2017 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52. The inpatient claims were adjusted to pay the correct number of days per the Prior Authorization (PA) on file.

If the hospital received 2 PAs from Beacon Health Options for the one inpatient admission, the claim was reprocessed only using 1 PA on file. The reprocessed inpatient claim only had one room and board detail on the claim thereby not using all the units from both PAs, causing the claim to cut-back the reimbursement. DXC Technology is currently reviewing the issue and will update the providers once a resolution is reached.

Outstanding Questions

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

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

- 10/1/2017 – 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. A process is currently being developed and the Department will provide guidance and billing instructions once system updates have been made. Please hold on to any reviews until further notice.

Outpatient Therapies Claims

- 10/1/2017 - The hospitals have requested DXC to review outpatient therapies claims not reimbursing up to the flat rate due to the first detail billing less than the contract rate and the second detail denying as a duplicate. DXC has reviewed the outpatient claims and is working on system updates.

Reminders / Updates

Explanation of Benefit (EOB) Code 839 ""NDC is not valid for procedure code billed".

This notification serves to remind providers of the edit that validates the National Drug Code (NDC) submitted on the claim. The submission of the NDC on outpatient, and crossover claims allows the Department of Social Services (DSS) to collect drug rebate dollars on Healthcare Common Procedure Coding System (HCPCS) drug procedure codes from pharmaceutical manufacturers. The edit will validate the association of the 11-digit NDC to the HCPCS when billing physician administered drug procedure codes in the J, S or Q series on outpatient, and crossover claims for Revenue Center Codes (RCC) 250, 253, 258-259 and 634-637 which require a HCPCS code and the corresponding NDC. Claims submitted where the NDC and procedure are not associated to each other will post an EOB code 839.

For example, a claim submitted for J1110 (Injection, dexamethasone sodium phosphate, 1mg) with an NDC 00006046102 for Emend would deny with EOB code 0839 "NDC is not valid for procedure code billed". Per the provider drug search, the NDC should have been billed with J8507.

To access the Provider Drug Search tool from the www.ctdssmap.com Web site, go to Provider, then Drug Search and enter at least one of the following: NDC or Drug Name in the appropriate field and click the search button to return the correct HCPCS.

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Updates to 835 Electronic Remittance Advice (ERA)

The following 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 1, 2017 and forward.

- For EOB code 5075 "Only One Interim Claim Allowed Per Stay" and EOB 5076 "Paid Interim and Final Claim for Same Admission Not Allowed" that was previously tied to CARC 273 RARC N362 has been changed and now will post CARC 119 RARC N130.

JW Modifier

Hospitals are reminded they are required to use the JW modifier when the hospital must discard the remainder of a single-use vial or other single-use package after administering a dose of the drug or biological, the Department will reimburse for the amount of drug/biological that was administered, as well as discarded with the use of the JW modifier.

For example, a single use vial that is labeled to contain 100 units of a drug has 95 units administered to a HUSKY Health member with 5 units discarded. The 95 units are billed on one detail line, while the discarded 5 units are billed on a separate detail line with the JW modifier. Both details will process for payment.

ICD-10 Diagnosis Codes Not Covered for Date of Services (DOS)

For dates of service October 1, 2017 and forward, the ICD-10 (International Statistical Classification of Diseases) code sets used to report medical and behavioral diagnoses will be updated and there will be some ICD-10 diagnosis codes that will no longer be valid. Any claim that is billed with an invalid diagnosis code will deny with Explanation of Benefit (EOB) code 4027 "Diagnosis Code Not Covered for Date of Service" for dates of service October 1, 2017 and forward. In many cases, the diagnosis code could require an additional digit. Providers should refer to the American Medical Association ICD-10-CM 2018 book for a list of valid diagnosis codes for dates of service October 1, 2017 and forward.

Medical and Behavioral Health Hospital Readmissions on the Same Date of Service.

When a member is discharged from an acute care hospital and subsequently readmitted to the same hospital on the same date of service for symptoms related to the original admission, the original and subsequent stay must be combined onto a single claim. The applicable Administrative Service Organization (ASO), Community Health Network of Connecticut (CHNCT) or Beacon Health Options must be notified of the subsequent inpatient admission so that the original authorization can be modified to cover both admissions.

If a member is discharged from an acute care hospital and readmitted on the same date of service for symptoms unrelated to the initial admission, the hospital must request a second prior authorization from the applicable ASO. The hospital must have a second authorization on file to allow separate claims to pay.

If the initial inpatient stay is medical in nature and the subsequent admission is behavioral health in nature, two separate claims may be submitted for reimbursement. Prior authorization must be obtained from each of the applicable ASOs for both admissions.

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Primary Insurance denying claim due to not receiving information (TPL survey) from client, then billing to Medicaid.

- In cases where the primary insurance to Medicaid is denying the claim due to not receiving information from the client, the hospital should use the Legal Notice of Subrogation Form (W-81) when initially pursuing commercial health insurance. This puts the insurance company on legal notice that it must make any payment for which it is liable for directly to the provider.

- If the hospital does not receive payment within forty-five days, they should fully document that every reasonable attempt was made. The provider must file a request for assistance with the Connecticut Department of Insurance using form W-82, Request for Assistance in Obtaining Payments. Department of Insurance will furnish the hospital with a file/case number.

- DSS is aware that other insurance carriers never cover some services. In addition, there are some insurance companies that do not provide an actual denial statement or, in some cases, never respond to written requests. To address these problems and to alleviate any unnecessary burden on the provider, DSS implemented the Third Party Billing Attempt, (W-1417). This form documents that the hospital has made every attempt to obtain payment from the other insurance carrier prior to claim submission to the Connecticut Medical Assistance Program. The form may be used in place of a denial voucher for the other insurance carrier, but may not be used in place of a Medicare denial. If the provider has not received any insurance payment within ninety days of the **date of the initial claims submission**, then the provider may bill the Connecticut Medical Assistance Program. **The Department of Insurance file number is required on the W-1417 form. Failure to include the Department of Insurance file number will result in the claim being returned to the provider.**

These instructions can be found under Provider Manual Chapter 5 "Claim Submission Information" on the www.ctdssmap.com Web site under the hospital modernization page, by clicking on Provider Manuals on the right side of the page. The forms can be downloaded from the www.ctdssmap.com Web site, under Information and then Publications and scrolling down to Third Party Liability Forms.

Re-enrollment for Hospital

The hospitals are reminded to take note of their re-enrollment due date with Medicaid. Failure to complete the re-enrollment process **by the re-enrollment due date** will cause the hospital to be dis-enrolled on the 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.

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.

Midstate Medical Center re-enrollment due date 10/18/2017 – Inpatient Psychiatric Unit
John Dempsey Hospital 12/11/2017 – Inpatient Acute Care and Psychiatric Hospital
Danbury Hospital 12/31/2017 – Inpatient Rehabilitation Hospital