interChange Provider Important Message

Hospital Monthly Important Message Updated as of 07/17/2017

*all red text is new for 07/17/2017

The following documents were recently updated:

CMAP Addendum B
The Department of Social Services (DSS) has 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 and APC weight changes with an effective date of January 1, 2017 was updated in the system on March 1, 2017. DXC Technology will re-process any impacted claims in a special claim cycle. 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.

CMAP Addendum B July 2017 updates are coming soon, a separate important message will be posted as soon as the July version of the CMAP Addendum B is posted to the Web. The updates are tentatively scheduled for Tuesday July 25, 2017.

Provider Bulletin 2017-50 – Coding Change for Hydroxypogesterone Caproate

For dates of service July 1, 2017 and forward, outpatient hospitals must use one of the following HCPCS codes listed below in place of J1725, either Q9985 "Injection, hydroxyprogesterone, caporate, NOS 10 mg" or "Q9986 "Injection, hydroxyprogesterone, caporate, (Makena), 10 mg."

Provider Bulletin 2017-45 – Eteplirsen Coverage Guidelines

Effective July 1, 2017, the Department of Social Services (DSS) is implementing a Prior Authorization (PA) requirement for prescription benefit coverage of Eteplirsen, marketed as Exondys 51, for HUSKY A, HUSKY B, HUSKY C, HUSKY D, and Family Planning program clients.

PA requests for coverage of Eteplirsen must be submitted by the prescriber in the form of a letter of medical necessity to the Department's Medical Director. Letters of medical necessity should be faxed to (860) 424-4822 with the required documentation outlined in the Eteplirsen Coverage Guidelines.

Hospitals should be billing with HCPC code C9484 "Injection, eteplirsen" which is on the CMAP Addendum B.

Provider Bulletin 2017-43 – New Explanation of Benefit (EOB) Codes for Manually Priced Claims

Beginning on August 1, 2017 hospitals will begin to see the following new EOB code messages:

EOB 6000 "Suspended Manually Priced Claim Currently under Review."
EOB 9100 "Paid Manually Priced Claim."
EOB 9101 "Denied Manually Priced Claim."
EOB 9102 "Suspended Manually Priced Claims Requires Medical Summary for Further Review – Fax 1-877-413-4421."

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Provider Bulletin 2017-40 – Coding and Reimbursement Updates for Outpatient Hospitals

Effective for dates of service July 1, 2017 and forward, the Department of Social Services (DSS) has made the following updates for claims submitted by outpatient hospitals:

Low Dose CT Scan for Lunch Cancer Screening
Beginning July 1, 2017, providers should use code G0297 when submitting prior authorization requests and billing for Low Dose Computed Tomography (LDCT) lung cancer screening.

Skyla
Effective for dates of service July 1, 2017 and forward, DSS has changed the reimbursement rate for HCPCS code J7301 - Levonorgestrel-releasing intrauterine contraceptive system (Skyla) for non 340-B outpatient hospitals. Consistent with the payment types listed on CMAP's Addendum B, non 340-B outpatient hospitals will be reimbursed for Skyla based off of the Physician Office and Outpatient fee schedule.

Kyleena
Effective for dates of service July 1, 2017 and forward, a unique HCPCS code has been assigned to Kyleena. Outpatient hospitals should no longer bill Kyleena under C9399 - Unclassified Drugs or Biologicals and must instead use the assigned HCPCS code Q9984 – Levonorgestrel-releasing intrauterine contraceptive system (Kyleena) with the appropriate NDC.

Provider Bulletin 2017-39 – HUSKY Plus Coverage Update

In an effort to streamline processes, the Department of Social Services (DSS) effective July 1, 2017 has integrate HUSKY Plus into the current administrative processes used for HUSKY A, B, C and D. HUSKY Plus provides supplemental coverage of goods and services for eligible HUSKY B members under the age of 19 years old; who have intensive physical health needs and have exhausted one or more of their benefits covered under the HUSKY B plan.

Effective July 1, 2017, there are also updates to HUSKY Plus which include changes to the prior authorization (PA) process, claims processing and processing payments for reimbursement. Please refer to the table under the provider bulletin for a complete list of code groups and the associated procedure codes under HUSKY Plus.

Claims for dates of service on or after July 1, 2017 must be submitted electronically to DXC Technology or through the www.ctdssmap.com Secure Web portal.

Provider Bulletin 2017-38 – Nusinersen Coverage Guidelines

Effective May 1, 2017, the Department of Social Services (DSS) implemented a Prior Authorization (PA) requirement for prescription benefit coverage of Nusinersen, marketed as Spinraza™, for HUSKY A, HUSKY B, HUSKY C, HUSKY D, and Family Planning program clients.

PA requests for coverage of Nusinersen must be submitted by the prescriber in the form of a letter of medical necessity to the Department's Medical Director. Letters of medical necessity should be faxed to (860) 424-4822 with the required documentation outlined in the Nusinersen Coverage Guidelines.

HCPC code C9489 "Injection Nusinersen" will be added to the July 2017 CMAP addendum B.

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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.

Provider Bulletin 2017-28 – Updated Guidelines for Smoking Cessation Agents, Counseling and Treatment Products

Effective July 1, 2017 this policy transmittal supersedes PB 11-94, "Expansion of Smoking Cessation Agents, Counseling and Treatment". The intent of this policy transmittal is to remind providers of the Connecticut Medical Assistance Program (CMAP) policies related to individual smoking cessation and smoking cessation treatment products to update coding, and to clarify billing for individual smoking cessation counseling in the outpatient hospital setting must be performed in conjunction with a medical clinic, emergency department (ED) or behavioral health (BH) outpatient visit.

When individual smoking cessation counseling is provided by a licensed behavioral health clinician during an established behavioral health outpatient visit, the hospital may bill on behalf of the BH clinician. Outpatient hospitals must bill procedure codes 99406 and 99407 in conjunction with Revenue Center Code (RCC) 914 – Individual Therapy when individual smoking cessation occurs during an established behavioral health visit. Since BH services in the outpatient hospital setting are paid using bundled rates, the BH clinician may not bill separately for professional services.

Effective for dates of service July 1, 2017 and forward, procedure codes 99406 and 99407 will be payable on CMAP's Addendum B only when performed as part of an established behavioral health visit, when the new CMAP Addendum B comes out in July.

As a reminder when individual smoking cessation is provided as part of a medical outpatient hospital clinic visit or an emergency department visit, the hospital is not eligible for additional payment under CPT codes 99406 and 99407. The non-behavioral health provider may submit for reimbursement as a separate professional claim.

Closed Questions / Issues

Update to the Consent to Sterilization Form Submission (Federal Form OMB No. 0937-0166), Hysterectomy Information Form (W-613) and Physician Hysterectomy Certification Form Retroactive Eligibility (W-613A) Submission Process

Effective immediately, hospital can fax their form submissions to DXC Technology at 1-860-986-7995.

The mailing address changed to DXC Technology PO Box 2971 Hartford, CT 06104.

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Emergency Department Accident Related Request Forms

Hospitals are receiving a high number of Emergency Department Trauma related request forms looking for additional documentation.

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 DXC Technology 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.

- 7/1/17 - DSS is required to identify Medicaid claims with a trauma, injury, or illness related diagnosis code to determine if there is other third party liability responsible to pay for client health care costs. This requirement is met through the DXE Technology Trauma Claim Review Process (trauma process). The trauma process targets hospital claims only. Further, the trauma process limits hospitals from receiving duplicative and redundant trauma letters. Once a trauma case is established and letter sent to the hospital, the client will be excluded from trauma review for the next 180 days.

For any additional questions the hospitals can contact the Office of Quality Assurance at DSS.

Reduced/Discounted services

- 7/17/2017 - Currently reduced and discounted services are not payable and identified when billed with Modifier 52 "Reduced Services" and Modifier 74 "Procedure Discounted after Anesthesia" and will deny with EOB 0335 "APC - REDUCED/DISCONTINUED PROCEDURES ARE NOT PAYABLE." DSS has review the hospital's request and at this time and these services will continue to be not payable and the only time we will consider modifier 52 is when it is billed in connection to Intensive Outpatient Program (IOP) or Partial Hospitalization Program (PHP) services.

Inpatient Admit Changes from Medical to Psychiatric

When a HUSKY client is admitted and the primary reason for the admission is medical in nature, the hospital should request a medical PA from CHNCT to process the authorization through discharge. If the client is subsequently transferred to a psychiatric unit, the hospital should administratively discharge (Patient Status 65) the client from medical and re-admit the client to behavioral health (Admit Source D) to qualify for the per diem rate for the behavioral health portion of the stay. Upon re-admission to behavioral health, the hospital should request a per diem PA from CT BHP to process the authorization through discharge. In this case, the hospital must submit two separate inpatient claims, with two different admit dates.

7/1/2017 - DXC Technology had identified an issue with inpatient admissions that change from medical to psychiatric. In cases where the behavioral health inpatient prior authorization is longer than the actual inpatient behavioral health stay could cause the inpatient claim to pay incorrectly. Previously we asked the hospitals to contact Beacon Options to update the current inpatient behavioral authorization. The hospitals should no longer contact Beacon Options to update an inpatient authorization in these situations and wait for the system update. The system was updated on Tuesday June 27, 2017 to correct this issue and the hospital can re-submit or adjust any inpatient claims that were processing incorrectly.

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EviCore

7/1/2017 - Hospitals are stating that when they try to get a Prior Authorization (PA) from EviCore and they use the online PA registration it comes up with their inpatient NPI instead of their outpatient. DSS has contacted EviCore and they have corrected the issue as of Monday July 17, 2017.

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.

- 7/1/2017 – 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.

National Drug Code billing

- 7/10/2017 – When hospitals bill two different NDCs on two different detail lines using the same HCPCS codes, the second detail line is being denied as a duplicate. The second detail is denying even when the hospital has received PA for these services or these services are payable, non-packaged code according to CMAP's Addendum B. DXC Technology and DSS have reviewed this issue and will be making a system update to bypass the duplicate edit in times when the NDC code is different. The system was update to bypass the duplicate edit in these cases on Thursday July 11, 2017 and any details that were previously denied as a duplicate can be adjusted.

Outpatient Therapies Claims

7/1/2017 - The hospitals have requested DXC to review outpatient therapies claims not paying up to the flat rate for their therapy codes. DXC is reviewing the outpatient claims provided and once the claims have been reviewed we will communicate the findings to hospitals by updating the hospital important message.

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.

Occupational Therapy Visits

The Department has updated the Prior Authorization (PA) requirements for Revenue Center Code (RCC) 431 – Occupational Therapy Visit. Effective for Dates of Service July 1, 2017 and forward, PA will be required for occupational therapy when there is greater than two visits per calendar week. The outpatient PA grid can be accessed from the Connecticut Medical Assistance Web Site: www.ctdssmap.com. From this web page, go to "Hospital Modernization", then click "Prior Authorization Grid for Outpatient Hospitals".