interChange Provider Important Message

Hospital interChange Updated as of 03/03/2016

*all red text is new for 03/03/2016

Ambulatory Payment Classification (APC) Scheduled for July 1, 2016

DSS will move from the current system of hospital outpatient payment methodology based on Revenue Center Codes (some paid based on fixed fees, some based on a ratio of costs to charges) to a prospective payment system based on the complexity of services performed. This change is scheduled for July 1, 2016.

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 document was recently added to the Hospital Modernization Web page:

- Hospital Modernization FAQs added 01/13/2016
- **Addendum B** has been approved by the department and added 02/19/2016

Provider Bulletin 2016-06 – Hospital Based Practitioners – Outpatient Services

The purpose of this bulletin is to inform hospitals that they will need to create and enroll as a practitioner group(s) in the Connecticut Medical Assistance Program (CMAP) in order to bill for outpatient professional services. If the hospital has already enrolled a practitioner group as directed by Provider Bulletin 2014-68 "Hospital Based Practitioners – Inpatient Services", they are not required to enroll as a separate group. The hospital can bill inpatient and outpatient professional services under the same group.

This will ensure that hospitals will be reimbursed outside of the Outpatient Prospective Payment System (OPPS) for their outpatient professional fees for dates of service July 1, 2016 and forward. Hospitals will also need to ensure their performing providers are enrolled in CMAP under a participation type of individual provider or as Employed/Contracted by an organization and associated to their the practitioner group. Instructions for adding members to their group(s) AVRS ID can be found in Chapter 10, Section 10.18 of the Provider Manual.

Provider Bulletin 2016-04 – Change in Timeframe for Requesting Authorization for Retroactive Eligibility

Effective January 1, 2015 for individuals that were granted eligibility after the time of admission, the provider must submit a request for authorization within the newly established timeframe per Regulation 17b-262-907(c):

For a member who is not eligible on the date of admission to the hospital and subsequently becomes retroactively eligible to any date included as part of such admission, the provider shall request authorization not later than thirty calendar days after eligibility is granted.

Provider Bulletin 2016-02 – Billing for Partial Payment for Behavioral Health Intermediate Levels of Care

The purpose of this provider bulletin is to notify acute care and psychiatric hospitals that, effective July 1, 2016, there is a new process for billing days on which an individual does not attend the entire scheduled duration of an intermediate level of care program.

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Intermediate levels of care are Partial Hospital Programs (PHP), Intensive Outpatient Programs (IOP) and Extended Day Treatment (EDT) Programs.

For services that qualify for partial day billing, the hospital should submit the appropriate Revenue Center Code (RCC) with one of the Healthcare Common Procedure Codes (HCPC) and modifier 52.

Provider Bulletin 2015-96 – Consolidated Laboratory Fee Schedule Update

Effective for dates of service January 1, 2016 and forward, the Department of Social Services has incorporated the 2015 HCPCS changes (additions, deletions and description changes) to its Consolidated Laboratory Fee Schedule.

Codes for many of the drug screens and drug assays in the G6030 to G6058 range, as well as codes G0431 and G0434 were discontinued for 2016. Medicare decided to continue to not recognize CPT codes 80300 – 80377. CMS has introduced three new presumptive drug testing codes (G0477, G0478, G0479) and four new definitive drug testing codes (G0480, G0481, G0482, G0483), effective January 1, 2016.

The Department added new molecular pathology codes 81162, 81170, 81218, 81219, 81272-81276, 81311, 81314, 81412-81493, 81525-81595 to the Laboratory fee schedule. A majority of the molecular pathology codes will require prior authorization (PA). Please check the fee schedule to determine whether the service being ordered or provided requires PA.

The consolidated laboratory fee schedule can be accessed and downloaded on the www.ctdssmap.com, from this Web page, go to "Provider", then to "Provider Fee Schedule Download", scroll down and click the "I Accept" button, then click on the "Lab" fee schedule.

Claims Reprocessing

The Department of Social Services wishes to notify providers that there were inadvertent errors in the fees posted on the Consolidated Laboratory Fee Schedule for drug testing codes effective 01/01/2016. The fees have been corrected. Please review the Consolidated Laboratory Fee Schedule posted to the Web site for corrected fees. Impacted claims were selected for rate mass adjustments and were processed in the 2nd cycle of February 2016 and appeared on your February 23, 2016 Remittance Advice.

Updates to 835 Electronic Remittance Advice (ERA)

In a response to a previous request from the hospitals the following update was made to the 835 ERAs starting with the January 13, 2016 835 ERA.

- EOB code 3003 utilizing CARC 204 "This service/equipment/drug is not covered under the patient's current benefit plan" and Remittance Advice Remark Codes (RARC) N130 "Consult plan benefit documents/guidelines for information about restrictions for this service" was changed to CARC 197 "Payment denied/reduced for absence of precertification/authorization and will not have a RARC."

- EOB code 1033 utilizing CARC 16 "Claim/Services lacks information" and RARC N253 "Missing/incomplete/invalid attending provider primary indicator" was changed to CARC B7 "This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present" and RARC N570 "Missing/incomplete/invalid credentialing data."

- EOB Code 0165 utilizing CARC 22 "Payment adjusted because this care may be covered by another payer per coordination of benefits" will additionally post RARC N598.

- EOB Code 0885 utilizing CARC 22 "Payment adjusted because this care may be covered by another payer per coordination of benefits" will additionally post RARC N598.

Updated Consent to Sterilization Form Posted to Web Portal

Hewlett Packard Enterprise has posted an updated Consent to Sterilization, Federal Form OMB No. 0937-0166, in both English and Spanish, to the Connecticut Medical Assistance Program (CMAP) Web site.

This form can be accessed by going to www.ctdssmap.com. From this Web page, go to "Information", then to, "Publications". Scroll down to the Forms section, and the links to the English and Spanish Consent to Sterilization forms are listed beneath the Authorization/Certification Forms section.

Office Closure

Please be advised, the Department of Social Services (DSS) and HPE will be closed on Friday, March 25, 2016 in observance of the Good Friday Holiday. DSS and Hewlett Packard Enterprise offices will re-open on Monday. March 28, 2016.

Outstanding Questions

Inpatient Admissions Following Outpatient or Emergency Department Services

Inpatient claims are denying with EOB codes 0671 "DRG Covered/Non-covered Days Disagree with the Statement Period" and 0672 "DRG Accommodation Days Inconsistent with the Header Date Period" for inpatient admissions following outpatient or emergency department services. Also some claims are denying with EOB code 529 "Surgical Procedure Date is prior to Admission Date."

- 03/01/2016 - ID and Reprocess of denied claims will be scheduled for a future cycle once system updates are completed.

- 02/29/2016 - The Department and HPE are working on system updates to EOB 671 to allow these claims to be considered for payment. EOB 672 was made inactive on 2/11/2016.

- 02/12/2016 – EOB code 529 was made inactive and inpatient claims that previously denied can be re-submitted for processing.

Billing for Emergency Department Professional Services Prior to an Admission

In cases where the client is outpatient or emergency room prior to an admission, the hospitals are requesting to be able to bill for professional fees separately on a CMS-1500. Effective for admission on or after January 1, 2015, hospitals can no longer bill for their inpatient professional fees (RCC 98X) on an inpatient claim and need to bill them on a CMS-1500.

- 02/10/2016 - Based on Provider Bulletin 2014-88 "Billing for Emergency Department Services", these policies and procedures will not be modified until the Department modernizes its outpatient hospital reimbursement methodology using Ambulatory

Payment Classifications pursuant to section 17b-239(d)(2) of the Connecticut General Statutes. That change is still scheduled for implementation on July 1, 2016 and will not occur earlier.

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

- 02/10/2016 - The Department has agreed that these claims should consider the co-pay amount and is working on updates to the system to allow claims to be considered for payment. DSS is reviewing the hospital's request to reprocess claims going back to January 1, 2014.

Transgender gender clients and the eligibility process.

The hospital was asking who they can contact to provide updates to the client's eligibility in these cases and if they can bill with condition code 45 "Ambiguous Gender Category" to override claims that deny due to gender not matching.

- DSS states hospitals can contact the DSS benefits center, but any eligibility updates could require the client to provide this informational change.

- 03/01/2016 - System updates will occur in the future to allow condition code 45 to override claims and the hospital important message will be updated when the system is updated.

Inpatient delivery stays denying due to lack of prior authorization when the delivery stays do not require prior authorization.

The Department of Social Service's criterion for identifying a delivery for an inpatient stay is based on the primary diagnosis on the claim. If the primary reason for the stay was a delivery Prior Authorization (PA) is not required. DSS has determined that the hospitals should be entering the birth diagnosis as the primary diagnosis on their claims to bypass the PA requirements. The hospitals have disagreed with this process and do not want to change their diagnoses.

- 03/01/2016 - DSS and Hewlett Packard Enterprise are making updates to include additional diagnoses to allow claims without PA and for hospital not to have to alter their claims. DSS and Hewlett Packard Enterprise are targeting updates for 1st cycle in March. After these updates are made HPE will provide the hospitals with a list of diagnosis that will allow an override of PA. If the hospital has claims with additional diagnoses that they believe should be considered for bypass, please send these claim examples to Hewlett Packard Enterprise at the following e-mail address: ctxixhosppay@hpe.com.

- 03/01/2016 – ID and Reprocess will be scheduled for a future cycle once updates are made.

Third party Liability (TPL) HMS Audits

The hospitals are questioning the audit process that is taking a lot of time due to high volume of claims selected by this audit. Most of the claims that are selected have a deductible and the other insurance pays zero. The hospitals are questioning why they are asking for primary voucher when the claim clearly states there is a deductible amount owed. If they don't provide that information in a specific amount of time the claims are voided and the money is recouped.

- 02/24/2016 – DSS thanks the hospitals for their inquiry. We appreciate the opportunity to address the Connecticut Hospital Association's concerns regarding the Department's Third Party Liability processes. Health Management Systems (HMS) performs the Third Party Liability Medicaid recovery 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.

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.

- 03/01/2016 - DSS is reviewing this issue to determine the best directions for the hospital and to determine if any system updates are needed.

Documenting outpatient claims are unrelated to inpatient claims

The Hospital asked if they needed any specific kind of documentation be added to their record keeping to deem that an outpatient claims is unrelated to an inpatient claims.

- 02/10/2016 - Hospitals should continue to document as they do today, ensuring all components of the visit are documented.