interChange Provider Important Message

Hospital Monthly Important Message Updated as of 10/8/2019

*all red text is new for 10/8/2019

CMAP Addendum B October 2019

The Department of Social Services (DSS) will be updating the Connecticut Medical Assistance Program (CMAP) Addendum B for dates of service October 1, 2019 and forward in October. The payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system prior to October 1, 2019. Any claims submitted for dates of service October 1, 2019 and forward that have a status indicator of G or K will process at the correct payment rate.

3M Grouper

The update to the ICD-10 (International Statistical Classification of Diseases) codes effective October 1, 2019 may cause inpatient Diagnostic Related Group (DRG) claims with header Through Date of Service (TDOS) October 1, 2019 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 which is tentatively scheduled for November. 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 Weight, Average Length of Stay (ALOS) and Outlier Threshold Updates – January 1, 2020

Per the amendment to Attachment 4.19-A of the Medicaid State Plan, the Department shall pay for hospital inpatient services on a fully prospective per discharge basis using DRG-based payments. Diagnosis related groups will be assigned using the most recent version of the 3M All Patient Refined Diagnosis-Related Grouper (APR-DRG) with each new grouper version released by 3M being implemented the subsequent January 1st. DRG Weights, average length of stays and outlier thresholds for the new version will all have an effective date of January 1, 2020.

Provider Bulletins

Provider Bulletin 2019-60 "Increasing the Reimbursement Rates for Selected Long-Acting Reversible Contraceptive Device."

The Department of Social Services (DSS) updated the reimbursement rate for Liletta and Etonogestrel implant, a Long-Acting Reversible Contraceptive Device (LARC). Effective for dates of service October 1, 2019 and forward, DSS is increasing the reimbursement rate for Liletta on the physician office and outpatient fee schedule to $934.82 and Etonogestrel implant to $749.40.

Reimbursement for LARC devices in the outpatient hospital setting will be determined by the specific procedure code billed for the LARC device inserted/placed. The reimbursement rate for LARC devices will be the rate published for the specified procedure code on the physician office and outpatient fee schedule or, for 340B hospitals, the family planning clinic fee schedule.

Provider Bulletin 2019-59 "Authorization for Palivizumab (Synagis®) - 2019-2020 Respiratory Syncytial Virus (RSV) Season"

This bulletin provides important information to providers regarding the clinical and prior authorization (PA) requirements for palivizumab (Synagis®) procedure code 90378 for the 2019-2020 Respiratory Syncytial Virus (RSV) season. Synagis® is used as prophylaxis against RSV, the most common cause of bronchiolitis and pneumonia in young infants. Prior authorization (PA) for Synagis® is required when provided to HUSKY members on an outpatient basis.

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Provider Bulletin 2019-53 – **Updates to Genetic Testing Prior Authorization Form**

Effective September 1, 2019 and forward, the Genetic Testing Prior Authorization (PA) Request Form has been updated. The updated form should be used beginning September 1, 2019.

PA request forms are available on the HUSKY Health Web site at: www.ct.gov/husky. To access the forms, click on For Providers, followed by Prior Authorization Forms and Manuals under the Prior Authorization menu item.

Inpatient Delivery Stay

Inpatient delivery stays denying due to lack of prior authorization when the delivery stays do not require prior authorization. DSS' criterion for identifying a delivery for an inpatient stay is based on the primary diagnosis code on the claim. If the primary reason for the stay was a delivery, then Prior Authorization (PA) is not required. DSS has determined that there were ICD-10 diagnosis codes that should have bypassed the PA requirement on an inpatient delivery stay.

Diagnosis codes that were denied by DSS, either had a childbirth specific diagnosis code in the series, which is the appropriate code to use instead of the trimester code (i.e. O10.013 "Pre-existing essential hypertension complicating pregnancy, third trimester", if there was a delivery the hospital should use O10.02 "Pre-existing essential hypertension complicating childbirth" or were denied because the diagnosis code in question should not be considered as the primary code on the claim. In other circumstances, the hospital should be using a more specific code under ICD-10 versus selecting "unspecified".

If the hospital still believes there are other diagnoses that should be considered to bypass PA when a delivery occurs, please send claim examples (including ICN) to DXC Technology at the following e-mail address: ctxixhosppay@dxc.com.

TPL Audit Report – October 2019

The Third-Party Audit reports were sent to the following hospitals on October 1, 2019:

Stamford Hospital, Gaylord Hospital and St. Vincent's Medical Center.

Trauma Questionnaire

As of Wednesday September 17, 2019, hospitals have the option to fax their trauma questionnaire form and documentation to DXC Technology to 1-833-577-3519. Hospitals may also continue to mail the form and any documentation to DXC Technology P.O. Box 2981 Hartford, CT 06104.

DSS has updated the trauma questionnaire form to include the fax number.

DXC Technology has updated the delivery process of how trauma questionnaires are sent to the hospitals. The hospitals will now receive all trauma questionnaires in one downloadable PDF file on their secure Web account at www.ctdssmap.com. Once logged on, select Trade files > download and under Transaction Type select Trauma Questionnaire.

Medicare Exhausted Inpatient Claims

Medicaid's payment will be limited to the full coinsurance and/or deductible on an inpatient Medicare crossover claim where Medicare has been exhausted. When Medicare is exhausted during a hospital stay, it is no longer acceptable to cut back the dates of service on the crossover claim and then bill Medicaid directly, via an inpatient claim, for the dates of service after Medicare has been exhausted. The Medicare inpatient crossover claim should be submitted in its entirety to include the total stay. Medicaid's payment will only be for the Medicare coinsurance and/or deductible.

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Medicaid will continue to consider the Part B covered charges of an inpatient stay when Medicare has been exhausted. There are no billing changes for these outpatient crossover claims.

If Medicare Part A denies the entire stay as exhausted the hospital should submit part B charges to Medicare for processing and if Medicare Part B makes a payment, the non-crossover inpatient claim must be billed by indicating the Part A denial and Part B payment. The Part B payment in the paid amount field must equal the sum of the Medicare paid amount, coinsurance amount and the deductible amount located on the Explanation of Medicare Benefits.

When Medicare denies the entire stay as exhausted and the client has Qualified Medicare Beneficiary (QMB) Medicare Covered Services only, there will be no reimbursement for the non-crossover inpatient claim.

Provider Manual Chapter 12 – Claim Resolution Guide

Provider manual chapter 12 provides a detailed description of the cause of each Explanation of Benefits (EOB) and more importantly the necessary directions to resolve the error. This guide also provides where hospital can go to find additional information to assist with correcting their claims.

National Correction Coding Initiative (NCCI) Edits

Explanation of Benefits (EOB) Code 5924 "Claim denied, CCI greater and lesser procedures are not covered on same date of service."

EOB 5925 "CCI column 1 code or mutually exclusive code was billed on the same date as previous column 2 code."

EOB 5926 "CCI column 2 code was billed on the same date as previous column 1 or mutually exclusive code."

Procedure to Procedure (PTP) edits are defined as pairs of HCPCS/CPT codes that should not be reported together on the same date of service for a variety of reasons and prevent reimbursement for both procedures.

Visit the CMS Web site https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html for PTP code edits and the use of modifiers to bypass these edits.

Late or Corrected Charges

If the hospital needs to submit late or corrected charges, but the claim is past timely filing the hospital should not adjust the claim. If the hospital adjusts the claim it will deny and recoup the monies in full. In the case of late charges, they need to submit the original claim to DXC Technology written correspondence to request for an override of timely filing to pay the original amount.

For corrected charges due to the change in procedure code, if the hospital adjusts the claim it will denied that detail as timely filing. If the total amount of that claim will pay less due to change in procedure code, the hospital should be submitting those corrected claims to DXC Technology written correspondence for an override of timely filing request due to the claim paying less.