April 18, 2018

Hospital Refresher Workshop

Presented by

The Department of Social Services

& DXC Technology

Presenter Paul Tom

DXC.technology

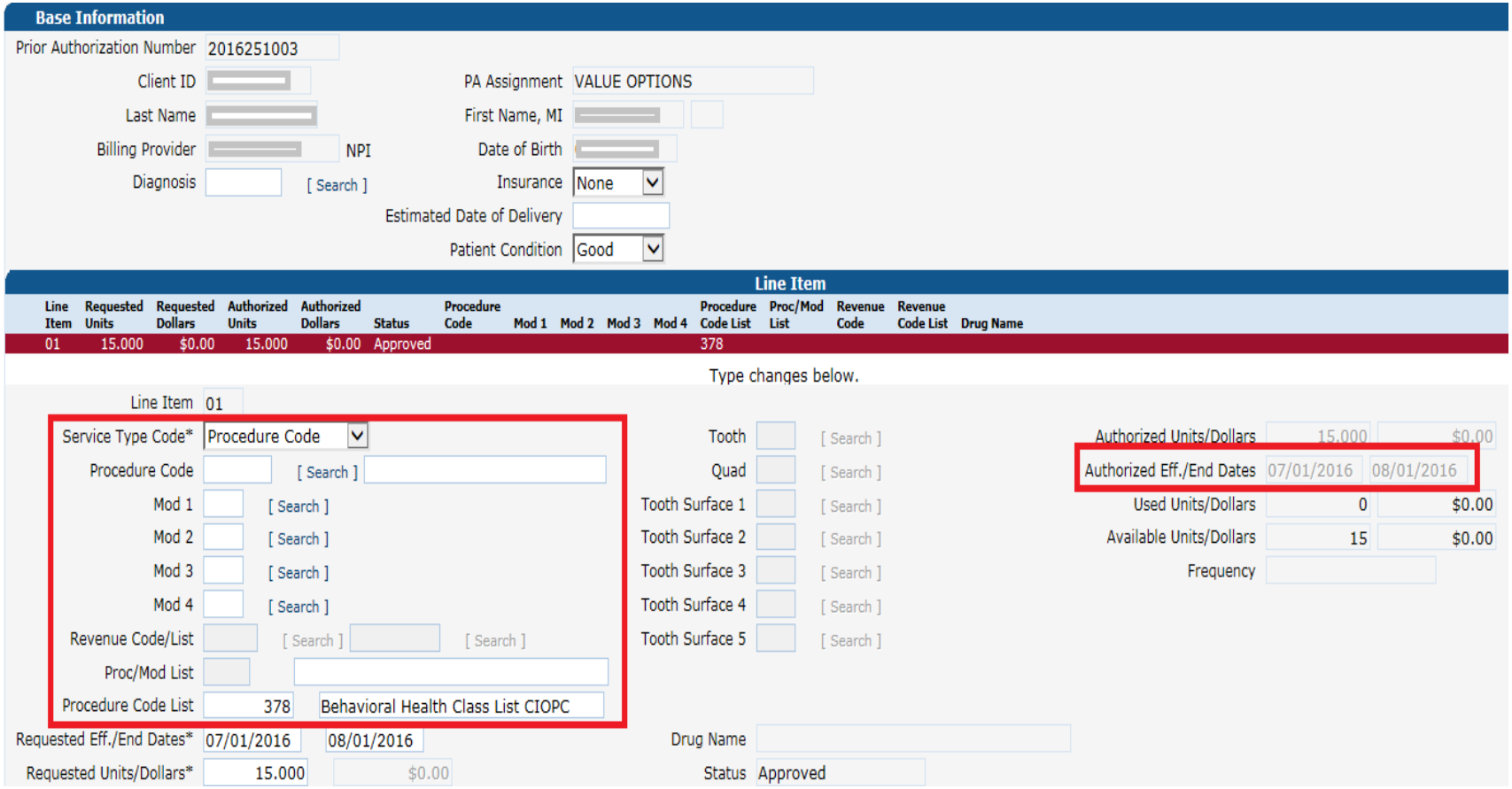
Training Topics

- Prior Authorization
- Web Claim Submission
- Web Claim Adjustments
- CMAP Addendum B
- Outlier Payments
- All Patient Refined-Diagnostic Related Group (APR DRG)
- Timely Filing Guidelines
- Frequent Claim Denials
- Hospital Modernization Page
- Questions

Prior Authorization

Prior Authorization

- **How to determine what services were authorized on an outpatient behavioral health Prior Authorization (PA) on the www.ctdssmap.com Web site.**



Prior Authorization

The prior authorization was for procedure code list 378 for authorized effective dates July 1, 2016 to August 1, 2016 for 15 units

- **To determine what services were authorization the hospitals can use the following crosswalk.**

Crosswalk – RCC/CPT/HCPCS to Procedure Code List

RCC	Description	Billable CPT/HCPC Code	Procedure Code List
900	Psych Treatment	90791, 90792, 90785	368, 378, 390, 391
901*	Electroshock Therapy	90870	N/A
905	Intensive Outpatient Program (IOP) - MH	S9480	378
906	Intensive Outpatient Program (IOP) - SA	H0015	378
907	Extended Day Treatment (EDT)	H2012	368
913	Partial Hospitalization Program (PHP)	H0035	391
914	Individual Therapy	90832 – 90838	390
915	Group Therapy	90853	390
916	Family Therapy	90846-90847, 90849	390
918	Psychiatric Testing	96101, 96116, 96118	395
919	Other BH (Med Management)	99201 - 99205, 99211 - 99215	390
919	Other BH (Autism)	0359T, H0046, H2014	1196
919	Other BH (Autism)	0372T	1203
919	Other BH (Autism)	H0031	1197
919	Other BH (Autism)	H0032, H0032 TS	1198
919	Other BH (Autism)	H0046	1202
919	Other BH (Autism)	H2014	1199

Prior Authorization

- **The prior authorization example was for Intensive Outpatient Services (IOP) – MH or Intensive Outpatient Services – SA based on the crosswalk.**

- **If the outpatient claim denied for Explanation of Benefit (EOB) 3003 “Procedure Requires PA” the hospital needs to verify the procedure code list on the PA with the services they are billing for on the outpatient claims. If they do not correspond to each other then either the hospital is billing the wrong RCC and procedure code or the authorization is not for the services they are billing for and the hospital would need to contact Beacon Health Options.**

  - **One exception to crosswalk is when the hospital receives a prior authorization for RCC 901 CPT 90870 “Electroshock Therapy” it will show on the prior authorization under the Revenue Code list instead of procedure code list with Revenue Code/List 2024.**

Prior Authorization

Overlapping Inpatient Authorization

- **If the hospital received 2 inpatient behavioral health prior authorization for one inpatient stay and the hospital is billing the entire stay under one inpatient claim, this could cause the incorrect amount of days to be paid on the claim.**

- **If the inpatient claim pays incorrectly the hospital should void the inpatient claims and contact Beacon Health Options to request an update to the PA to match the inpatient claim. Beacon Health Options will update the PA once the units are decremented from the PA.**

Prior Authorization Reminder for Advanced Imaging Services

- **Hospitals must confirm that a valid, approved authorization is on file for the appropriate Healthcare Common Procedure Coding System (HCPCS) "C" code instead of the Current Procedural Terminology (CPT) code. For a list of corresponding codes, the providers can refer to provider bulletin 2017-27 "Reminder About Use of "C" Codes for Certain Advanced Imaging Services."**

- **If the authorization on file does not have a "C" code, the outpatient claim will deny and the hospital would need to contact Community Health Network of CT (CHNCT) at 1-800-440-5071 to correct the PA.**

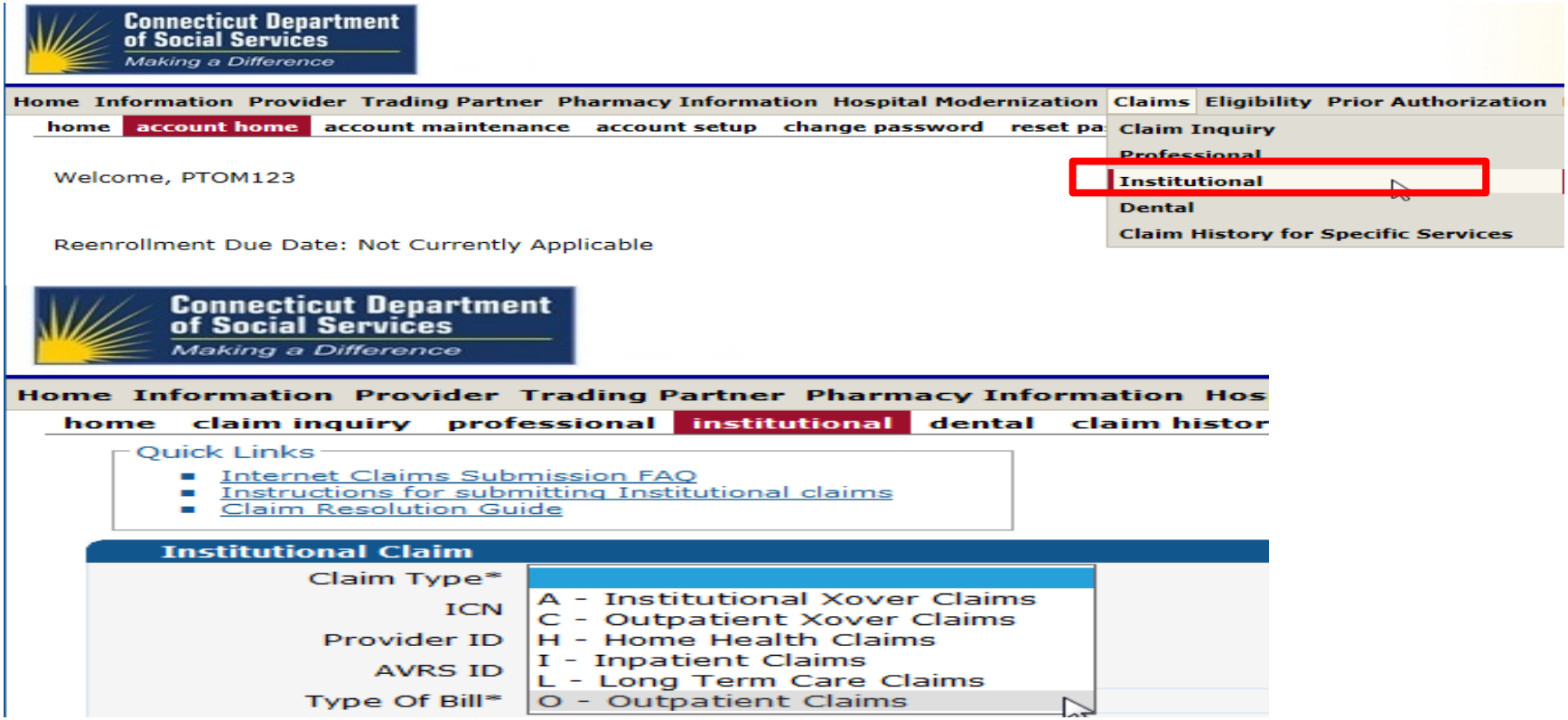
Prior Authorization

- **Hospital should refer to the Connecticut Behavioral Health Partnership Web site at www.CTBHP.com -> For Providers -> Covered Services > Authorization Schedule and select General and Psychiatric Hospital for behavioral health PA requirements.**

- **HUSKY Health Program benefits and authorization requirements for non-behavioral health services can be found on the HUSKY Health Web site at www.ct.gov/husky, under For Providers under Medical Management then select Benefit Grids.**
  - **Hospital can also refer to the Hospital Modernization Page on the www.ctdssmap.com Web site for the prior authorization grid for outpatient services.**

Web Claim Submission

To submit an institutional claim using the ctdssmap.com secure site, click on "Claims" on the main menu and then from the drop down menu select "Institutional." Once you do that you will need to select your claim type to start your claim.



Web Claim Submission

- Diagnosis and Detail Panels on an inpatient claim.

Web Claim Submission

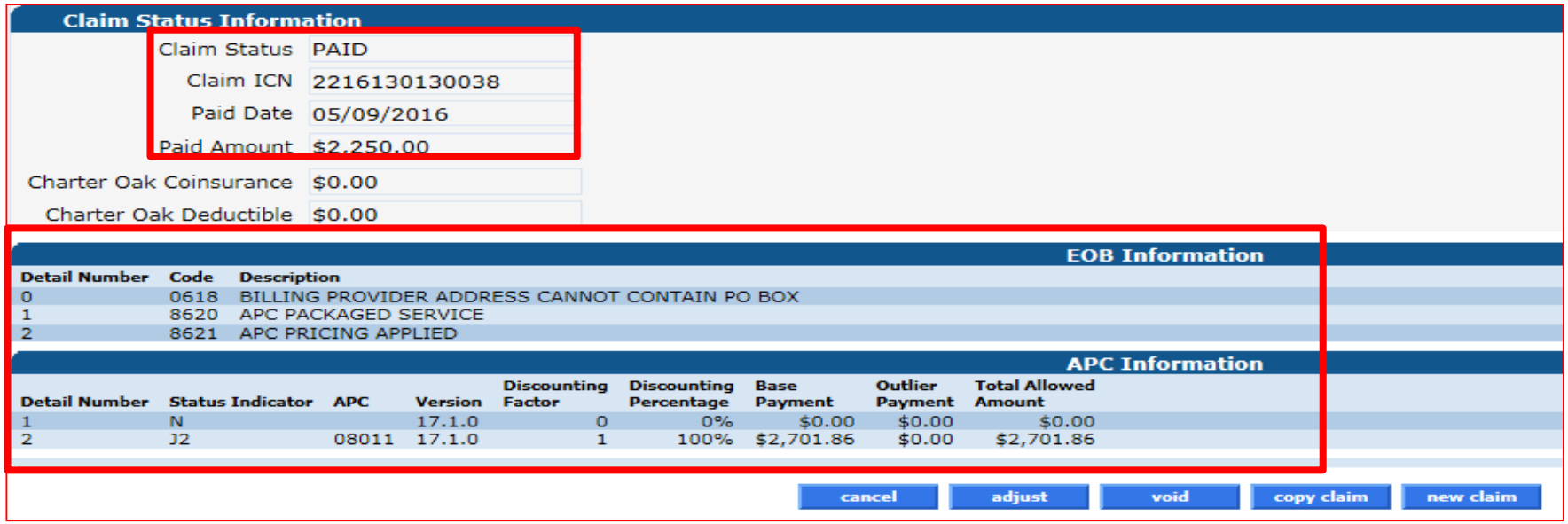
- **Revenue Code – Hospitals can use the Provider Type and Specialty to Revenue Center Code (RCC) Crosswalk on the hospital modernization page on the www.ctdssmap.com Web site to view the appropriate payable RCCs as limited by their scope of practice and Department policy.**
  - **If the hospitals bill with an inappropriate RCC that detail will deny with EOB code 4151 "Billing Provider Not Authorized to Bill for Submitted Service for Client".**

- **HCPCS – Refer to CMAP Addendum B on the hospital modernization page for a list of HCPCS/CPT.**

- **Modifiers – A list of the modifiers that could impact your payment on your claims has been added to the Hospital Provider Manual chapter 8 "Provider Specific Claims Submission Instructions" found on the www.ctdssmap.com Web site. It is not a full list of modifiers that can be used on your claim, you should refer to the CMS Web site www.cms.gov for an entire list of modifiers.**

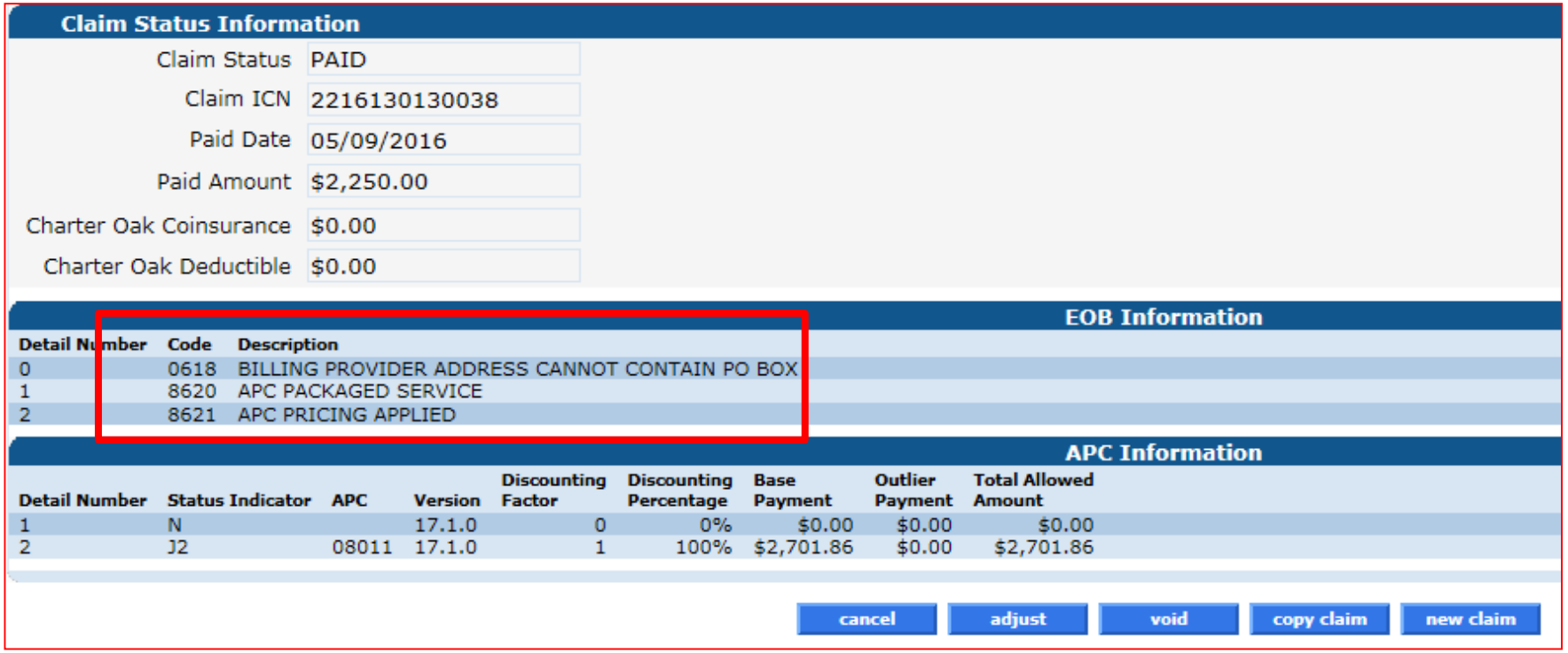
Web Claim Submission

Once all information is entered on your claim, hit submit to submit your claim to DXC Technology. Response from DXC Technology is immediate and will provide APC or DRG Information depending on your claim type.



Web Claim Submission

Explanation of Benefits (EOB) information – Explains how the claim or service pays, denies or suspends.



Claim Status Information

Claim Status	PAID
Claim ICN	2216130130038
Paid Date	05/09/2016
Paid Amount	$2,250.00
Charter Oak Coinsurance	$0.00
Charter Oak Deductible	$0.00

EOB Information

Detail Number	Code	Description
0	0618	BILLING PROVIDER ADDRESS CANNOT CONTAIN PO BOX
1	8620	APC PACKAGED SERVICE
2	8621	APC PRICING APPLIED

APC Information

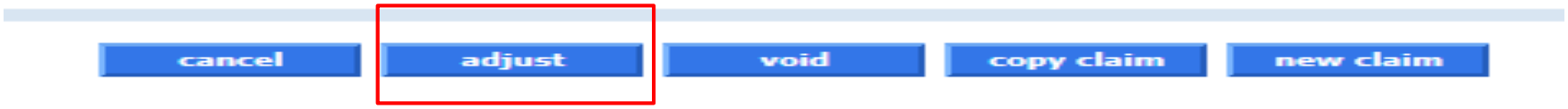
Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
1	N		17.1.0	0	0%	$0.00	$0.00	$0.00
2	J2	08011	17.1.0	1	100%	$2,701.86	$0.00	$2,701.86

cancel adjust void copy claim new claim

Web Claim Adjustments

After you submit a claim if you need to adjust a paid claim, you can perform the following steps to adjust your claim:

- **Select Claim Inquiry**
- **Perform search to find your claim and click the search button.**
- **Once the claim is retrieved, make any necessary changes to the claim.**
- **Click the adjust button at the bottom of the claim page.**



The following are web claim adjustment that <u>can</u> be submitted through the secure Web site www.ctdssmap.com.

- **Claims that are not past timely filing.**
- **Claims past timely filing that will pay the same or less than the original claim without the services being modified.**
- **Claims that do not have an ICN# that begins with a 12 or 13.**

Web Claim Adjustments

In these cases the hospital should void the original claim and submit a paper claim with the updated RCC and the RA to DXC Technology written correspondence requesting the claim be resubmitted with an override of timely filing.

- **Written correspondence request are submitted to:**
  DXC Technology
  Written Correspondence
  PO Box 2991 Hartford, CT 06104

Claims that begins with either ICN 12 or 13 were specially handled by DXC Technology. The hospital should contact the Provider Assistance Center (PAC) 1-800-842-8440 before attempting to adjust these claims on the Web.

CMAP Addendum B

Connecticut Medical Assistance Program (CMAP) Addendum B

- **CT Medicaid's OPPS processing is based on the CMAP version of Addendum B which is derived from Medicare's Addendum B. The differences between the CMAP version of Addendum B and the Medicare version of Addendum B primarily involve detail service coverage and pricing methodology.**

  - **Please refer to CMAP's Addendum B to determine which services will be paid based on fixed fee, fee schedule or APC assignment**

The CMAP Addendum B can be found on the "Hospital Modernization" page on the Web site www.ctdssmap.com under Important Messages – Connecticut Hospital Modenrization.

CMAP Addendum B

CMAP Addendum B April 2018 V19.1

Procedure Code	Short Descriptor	SI	APC	Relative Weigh	Payment Rate	Payment Ty	CT FEE SCHED	Chang
22849	Reinsert spinal fixation	C			MP	SURG		
23125	Removal of collar bone	J1	05113	33.6389	$2,645.23	APC		
23200	Resect clavicle tumor	C				No		
58300	Insert intrauterine device	E1			$275.76	PR		
58301	Remove intrauterine device	Q2	05411	2.0436	$160.70	APC		
58321	Artificial insemination	T	05412	3.4125	$268.35	No		
71045	X-ray exam chest 1 view	Q3	05521	0.79	$62.12	APC		New
77061	Breast tomosynthesis uni	E1				FS	PHRAD	
77065	Dx mammo incl cad uni	A				RCC	RCC 401	
77067	Scr mammo bi incl cad	A				RCC	RCC 403	
80408	Aldosterone suppression eval	Q4				APC-FS		
85060	Blood smear interpretation	B				NP		
90471	Immunization admin	Q1	05692	0.7401	$58.20	RCC	RCC 771	
93320	Doppler echo exam heart	N				APC		
97110	Therapeutic exercises	A				RCC	Therapy RCC	
C9492	Injection, durvalumab	G	09492		$73.60	APC-PR		G K
G0381	Lev 2 hosp type b ed visit	J2	05032	1.155	$90.82	APC		
J0885	Epoetin alfa, non-esrd	K	01686		$12.13	APC-PR		G K
S9480	Intensive outpatient psychia					FS-CMAP	Clinic/Op - BH if RCC = 905	

CMAP Addendum B

Payment Type - APC

- **If the payment type is APC Payment, it will be reimbursed using APC methodology**

- **Example: Procedure code 99283 “Emergency dept visit ”, payment type indicator “APC”.**

Procedure Code	Short Descriptor	SI	APC	Relative Weigh	Payment Rate	Payment Ty	CT FEE SCHED	Chang
99283	Emergency dept visit	J2	05023	2.7863	$219.10	APC		

- **APC Payment = (Provider Wage Adjusted Conversion Factor * units) * APC Relative Weight.**
  - **If the hospital’s wage adjusted conversion factor was $85.00, the APC allowance would be ($85.00 x 1) x 2.7863 = $236.84.**

CMAP Addendum B

Payment Type - APC – FS

- **Example: Procedure code 36415 “Routine Venipuncture”, payment type “APC-FS” and status indicator “Q4”.**

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
36415	Routine venipuncture	Q4				APC-FS		
80047	Metabolic panel ionized ca	Q4				APC-FS		

- **If the APC grouper returns the service as APC payable, this case will be reimbursed based on payment type “APC-FS” using the CT lab fee schedule.**

- **If the APC grouper returns a status indicator “N” the detail will be packaged and zero pay (no separate reimbursement).**

CMAP Addendum B

Status indicator is "Q1, Q2, Q3 or Q4" on CT Addendum B, but the APC grouper could return detail line with an "N" status.

- **Q1 – STVX-Packaged Codes**
- **Q2 – T-Packaged Codes**
- **Q4 – Conditionally Packaged Laboratory Tests**

  - **If there is another procedure code on the outpatient claim that is APC payable, the APC grouper usually would return a status indicator of "N" and the detail will be packaged. The detail will zero pay.**

  - **Services are only reimbursed when a non-patient and will pay off LAB fee schedule.**

- **Q3 – Codes that that may be paid through a composite APC**

  - **When payable separately from the APC payable code on an outpatient claim could pay a different APC code from CMAP Addendum B.**

Hospital Modernization - APC

Payment Type - NP – These services are only reimbursed when non-patient and will pay off LAB fee schedule.

- **Example: Procedure code 80050 “General health panel” payment type “NP”.**

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
80050	General health panel	E1				NP		X
80055	Obstetric panel	E1				NP		X
83992	Assay for phencyclidine	B				NP		X
85060	Blood smear interpretation	B				NP		X
86910	Blood typing paternity test	E1				NP		X
86911	Blood typing antigen system	E1				NP		X

CMAP Addendum B

Composite APC codes are not found on CT Addendum B. Status Indicator "Q3" could pay the APC code on the CMAP addendum B, but if it is billed with other services it can be paid through a composite APC code 08005-08008 which is not listed on CMAP Addendum B.

- **Example: Procedure code 70551 "Mir brain stem w/o dye", payment indictor "APC" and status indicator "Q3".**

Procedure Code	Short Descriptor	SI	APC	Relative Weigh	Payment Rate	Payment Ty	CT FEE SCHED	Chang
70551	Mri brain stem w/o dye	Q3	05523	2.9543	$232.31	APC		

- **APC grouper returns SI "S" and it will pay based on APC 05523 and relative weight 3.0121**

APC Information

Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
1	S	05523	18.0.0	1	100%	$238.29	$0.00	$238.29

CMAP Addendum B

- **Example: Procedure code 70551 “Mir brain stem w/o dye”, billed with procedure code 72141 and both procedures on CMAP Addendum B state payment type “APC” and status indicator “Q3”.**

Procedure Code	Short Descriptor	SI	APC	Relative Weigh	Payment Rate	Payment Ty	CT FEE SCHED	Chang
70551	Mri brain stem w/o dye	Q3	05523	2.9543	$232.31	APC		
72146	Mri chest spine w/o dye	Q3	05523	2.9543	$232.31	APC		

- **The claim goes through the APC grouper and 70551 status indicator is “S” with composite APC 08007 and 72146 status indicator is “N” packaged.**
- **APC payment would be based on the composite APC code.**

APC Information

Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
1	S	08007	18.0.0	1	100%	$581.98	$0.00	$581.98
2	N		18.0.0	0	0%	$0.00	$0.00	$0.00

CMAP Addendum B

Comprehensive APC codes are listed on CT Addendum B. Status Indicator "J1" could pay the APC code on the CMAP addendum B, but if it is billed with other services it can be paid through a comprehensive APC code which might be listed on CMAP Addendum B for another code.

- **Example: Procedure code 28300 "Incision of heel bone", payment indictor "APC" and status indicator "J1".**

Procedure Code	Short Descriptor	SI	APC	Relative Weigh	Payment Rate	Payment Ty	CT FEE SCHED	Chang
28300	Incision of heel bone	J1	05114	71.2959	$5,606.42	APC		

- **When billed by itself the APC grouper returns SI "J1" and it will pay based on APC 05114 and relative weight 71.2959**

CMAP Addendum B

- **Example: Procedure code 28300 “Incision of heel bone”, payment indictor “APC” and status indicator “J1” is billed with procedure code 28238 “Revision of foot tendon”.**

Procedure Code	Short Descriptor	SI	APC	Relative Weigh	Payment Rate	Payment Ty	CT FEE SCHED	Chang
28238	Revision of foot tendon	J1	05114	71.2959	$5,606.42	APC		
28300	Incision of heel bone	J1	05114	71.2959	$5,606.42	APC		

- **The claim goes through the APC grouper and 28300 status indicator is “J1” with comprehensive APC 05115 and 28238 status indicator is “N” packaged.**
- **APC payment would be based on the comprehensive APC code.**

Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
N		19.0.0	0	0%	$0.00	$0.00	$0.00
J1	05115	19.0.0	1	100%	$11,580.68	$0.00	$11,580.68

CMAP Addendum B

Status Indicator and APC Relative Weights

- **The relative weights used on the CMAP Addendum B are received from the Centers for Medicare & Medicaid Services (CMS) under Addendum A and Addendum B updates on the CMS Web site.**

- **The hospital can use the following link to get to the site:**
  - **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html**

- **Then select the most current Addendum A or Addendum B link April 2018, then click on "Accept" then "Open" and then select either "2018 April Web Addendum A 03.19.18" for relative weights or "2018 April Web Addendum B 03.19.18" for the Medicare's status indicator in excel or text format.**

- **The list of status indicators are located on the on the CMS Web site under Addendum D1 and the hospital can use the following link to get to the site:**
  - **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1506FC_Addendum_D1.pdf**

CMAP Addendum B

Payment Type APC-PR – Line item paid based on CMS payment rate.

- **Example: Procedure code C9492 “Injection, durvalumab”, payment type “APC-PR”.**
-

Procedure Code	Short Descriptor	SI	APC	Relative Weigh	Payment Rate	Payment Ty	CT FEE SCHED	Chang
C9492	Injection, durvalumab	G	09492		$73.60	APC-PR		G K
J1453	Fosaprepitant injection	K	09242		$2.05	APC-PR		G K

- **Status Indicator G “Drug Biological Pass Through” and K “Non-Pass Through Drugs and Biologicals”**
  - **If the procedure code payment type is APC-PR with a status indicator of G or K, it will be reimbursed based on the payment rate on CMAP Addendum B x the number of units up to the detail billed charges. We will pay lesser of billed charges verves the payment rate x units.**

CMAP Addendum B

Payment Type – FS – Line item paid based on CT policy (CT fee schedule payment).

- **Example: Procedure code 77062 “Breast tomosynthesis bi”, payment type “FS”.**

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED		Change
77061	Breast tomosynthesis uni	E1				FS	PHRAD		
77062	Breast tomosynthesis bi	E1				FS	PHRAD		
77063	Breast tomosynthesis bi	A				FS	PHRAD		

- **This procedure code would pay based on the Physician Radiology fee schedule.**

Payment Type - No – Line item denied based on CT policy.

- **Example: Procedure code 61796 “Srs cranial lesion simple”, payment type “No”.**

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
61796	Srs cranial lesion simple	B				No		
61797	Srs cran les simple addl	B				No		

CMAP Addendum B

Payment Type - No – Line item denied based on CT policy.

- **Example: Procedure code 89290 “Biopsy Oocyte Polar Body”, payment type “No”.**
- **Medicare does allow reimbursement for this codes and you can determine that based on the grey amounts in APC and relative weight fields, but Medicaid will deny the service based on CT policy and payment type “No”.**

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
89290	Biopsy oocyte polar body	Q1	5672	1.3850	$103.88	No		
89291	Biopsy oocyte polar body	Q1	5672	1.3850	$103.88	No		

CMAP Addendum B

Status Indicator N – Packaged

- **Line item details that return a "N" status indicator will be packaged, because the reimbursement for these items and/or services are included in the APC payment for another detail on the same date.**

- **The cost of the packaged services are allocated to the APC but are not paid separately. Some examples of packaged items are:**
  - **ancillary services;**
  - **implantable medical devices;**
  - **most clinical diagnostic laboratory tests; and**
  - **recovery room use.**

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
A4206	1 cc sterile syringe&needle	N				APC		

CMAP Addendum B

CMAP Addendum B - Legend Tab

Field Label	Field Description	Valid Values
Procedure Code	Five digit CPT or HCPCS code.	See CPT or HCPCS manual.
Short Descriptor	Short description for the procedure code field.	See CPT or HCPCS manual.
Status Indicator	The status indicator assigned by CMS. If the Payment Type value is APC, the status indicator will process according to CMS/Medicare guidelines.	See Medicare Addendum D1. * - Procedure code corrections added 1/22/2018 by CMS. SI values not yet available.
APC[1]	The APC group assigned by CMS for that procedure code.	See Medicare Addendum B for APC group and Medicare Addendum A for APC descriptions.
Relative Weight[1]	The relative weight assigned by CMS for the APC group assigned.	See Medicare Addendum A or Addendum B.
Payment Rate[1]	For procedure codes with a payment type of APC-PR and PR this field is the rate that the procedure code will be reimbursed. For procedure codes with payment type of SURG, this field indicates MP for manual priced or the rate the procedure code will be reimbursed.	
Payment Type	Identifies the payment method used by DSS to determine if and how the procedure code will be reimbursed.	APC — Reimbursed using APC methodology. APC-FS — APC (packaged) except a claim for a 'non-patient', then reimbursed based on the Lab fee schedule. APC-PR — APC reimbursed based on payment rate. FS — Reimbursed based on the CT fee schedule listed in the CT Fee Schedule field. FS-CMAP — Reimbursed based on the CT fee schedule listed in CT Fee Schedule field. These codes are not on Medicare's version of Addendum B. MP — Manually priced. No — Not covered by CT Medicaid (payment denied). NP — Service only reimbursed when non-patient and will pay off LAB fee schedule. PR — Reimbursed based on amount in Payment Rate field. RCC — Reimbursed based on revenue center code pricing.

CMAP Addendum B

CMAP Addendum B - Legend Tab Cont.

CT Fee Schedule	Identifies which fee schedule will be utilized for a given procedure code. Field is blank if service will not be paid using a fee schedule.	See CT Fee Schedule Legend.
Change	This field is only present on the Changes tab and indicates whether it is a changed or a new record. Discontinued codes have been removed.	New - The procedure code was added by CMS. G K - The procedure code has a status indicator G or K rate change. X - A change has been made to the procedure code or status indicator. Blank - No change

CMAP Addendum B - CT Fee Schedule Legend Tab

Fee Schedule Label	Fee Schedule Description
Clinic/OP - BH if RCC = 900	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 900. All other instances are not covered.
Clinic/OP - BH if RCC = 905	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 905. All other instances are not covered.
Clinic/OP - BH if RCC = 906	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 906. All other instances are not covered.
Clinic/OP - BH if RCC = 907	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 907. All other instances are not covered.
Clinic/OP - BH if RCC = 913	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 913. All other instances are not covered.
Clinic/OP - BH if RCC = 914	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 914. All other instances are not covered.
Clinic/OP - BH if RCC = 915	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 915. All other instances are not covered.
Clinic/OP - BH if RCC = 916	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 916. All other instances are not covered.
Clinic/OP - BH if RCC = 918	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 918. All other instances are not covered.
Clinic/OP - BH if RCC = 919	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 919. All other instances are not covered.

CMAP Addendum B

CMAP Addendum B - CT Fee Schedule Legend Tab Cont.

FP/OFOUT	For 340B providers use the Clinic-Family Planning fee schedule. For all others providers use the Physician Office and Outpatient fee schedule.
LAB	Lab fee schedule.
MEDS - DME	MEDS-DME fee schedule.
MEDS - Hearing Aid	MEDS-Hearing Aid/Prosthetic Eye fee schedule.
NDCLOW	Reimbursed based on the lower of Estimated Acquisition Cost (EAC), Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) for the NDC and units.
OFOUT	Physician Office and Outpatient fee schedule.
PHRAD	Physician Radiology fee schedule.
RCC 401	The procedure code must be billed with RCC 401 and will be reimbursed based on the rate on file for RCC 401 on the hospital outpatient flat fee schedule.
RCC 403	The procedure code must be billed with RCC 403 and will be reimbursed based on the rate on file for RCC 403 on the hospital outpatient flat fee schedule.
RCC 771	The procedure code must be billed with RCC 771 and will be reimbursed based on the rate on file for RCC 771 on the hospital outpatient flat fee schedule.
RCC 901	The procedure code must be billed with RCC 901 and will be reimbursed based on the rate on file for RCC 901 on the hospital outpatient flat fee schedule.
RCC 953	The procedure code must be billed with RCC 953 and will be reimbursed based on the rate on file for RCC 953 on the hospital outpatient flat fee schedule.
Therapy RCC	The procedure code must be billed with one of the appropriate therapy RCCs and will be reimbursed based on the rate on file for the RCC on the hospital outpatient flat fee schedule. (421,424,431,434,441,444)

CMAP Addendum B

Billing Changes Effective January 1, 2018

- **The following codes were deleted as of January 1, 2018**
  - **RCC code 401 “Diagnostic Mammography” Procedure codes G0204 and G0206 were deleted as of January 1, 2018**
  - **The hospital can continue to bill with procedure code 77065 or 77066.**
  - **RCC code 403 “Screening Mammography” Procedure code G0202 were deleted as of January 1, 2018**
  - **The hospitals can continue to bill with procedure code 77067.**

Outlier Payments

In addition to services being paid via the APC methodology outpatient claim might be eligible for an outlier payment.

Outlier adjustments ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers.

- **Similar to Medicare, in order for an outpatient claim to qualify for an outlier payment, two thresholds must both be met:**
  - **Multiple Threshold – The multiple threshold is met when the cost of furnishing an APC service or procedure exceeds the APC payment amount based on a defined multiplier.**
  - **Fixed-Dollar – The fixed-dollar threshold is met when the cost of furnishing an APC service or procedure exceeds the APC payment amount plus a fixed amount.**

Outlier Payments

- **The hospital outlier policy is calculated on a service basis using both fixed-dollar currently set for 2018 to $4,150.00 and multiplier thresholds set at 1.75 to determine outlier eligibility.**

($3825.00 for 2017 and $2,900.00 for 2016)

- **Outlier adjustment calculations will be applied to all details on the claim, even when the claim contains multiple dates of service.**

  - **If the fixed-dollar threshold and multiplier threshold is less then the total line cost which is calculated based on the equation (Covered charges * Hospital Cost-to-Charge-Ratio) an outlier add-on will apply.**

((Covered charges * Hospital Cost-to-Charge-Ratio) – 1.75 * APC payment) * 50% = outlier add-on payment.

APR DRG

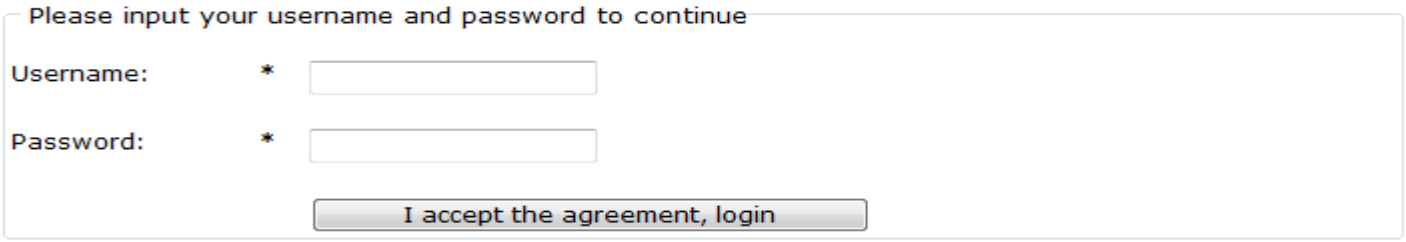
Inpatient Hospital claims are processed based on the Diagnostic Related Group (DRG) returned from the APR DRG grouper.

- **3M Health Information Systems has made a tool available to the hospitals to determine the APR DRG based on input of several data elements on the inpatient claim to determine the DRG code that will be used to price the claim.**
  - **The tool is available on the Web site www.aprdrgassign.com.**

- **In order to access this Web site, users will be required to enter a User ID and Password. To obtain this User ID and Password, please send a request via e-mail to ctxixhosppay@dxc.com.**

APR DRG

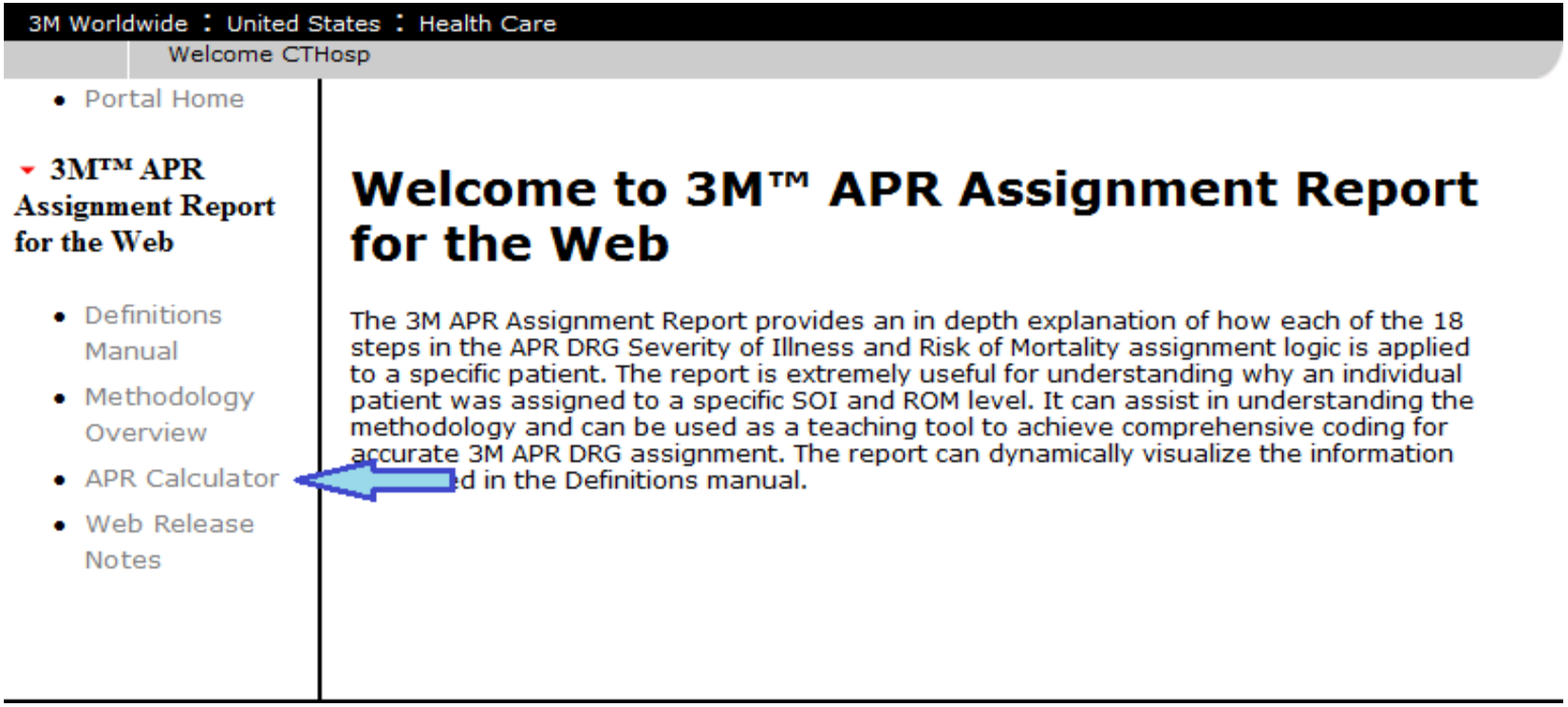
- **Once you receive the User ID and Password, you will need to read the terms and conditions, enter the User ID and Password and accept the agreement to log into the site.**



- **Then click on the APR DRG Assignment Report.**

APR DRG

- **3M Health Information Systems**

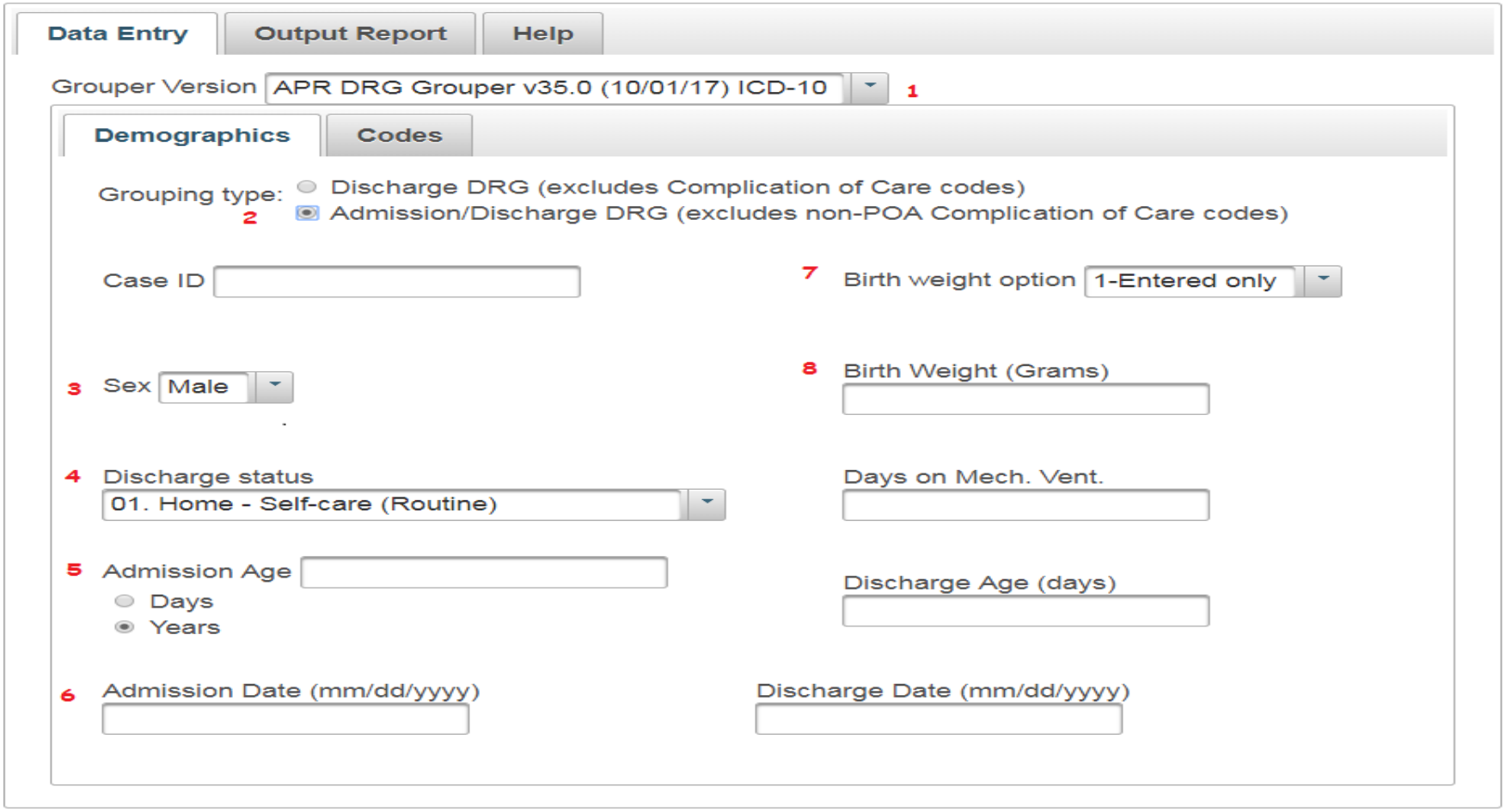


- **Click on APR Calculator.**

APR DRG

3M Health Information Systems

- **Data Entry Tab - Demographics**



APR DRG

3M Health Information Systems

- **Data Entry Tab - Demographics**

1. **Grouper Version – Select from drop down "APR DRG Grouper" v35.0 (10/01/15) ICD-10**

2. **Grouping Type – There are two options for the grouping type: Discharge DRG and Admission/Discharge DRG. The grouping type determines if the report will include both Admission and Discharge information, or just Discharge information.**
   - **Select: Admission/Discharge DRG (Excludes non-POA Complication of Care codes).**

3. **Sex – Select Male, Female, or Unknown.**

APR DRG

4. **Discharge Status – Select the patient status on the claim from the drop down selection.**

5. **Admission Age – Enter the age of the client at the time of admission in days or years.**

6. **Admission Date and Discharge Date – Enter the date of admission and discharge date of the inpatient stay.**

7. **Birth Weight Option* – Select 7 “Entered or coded w/default, X-chk”.**

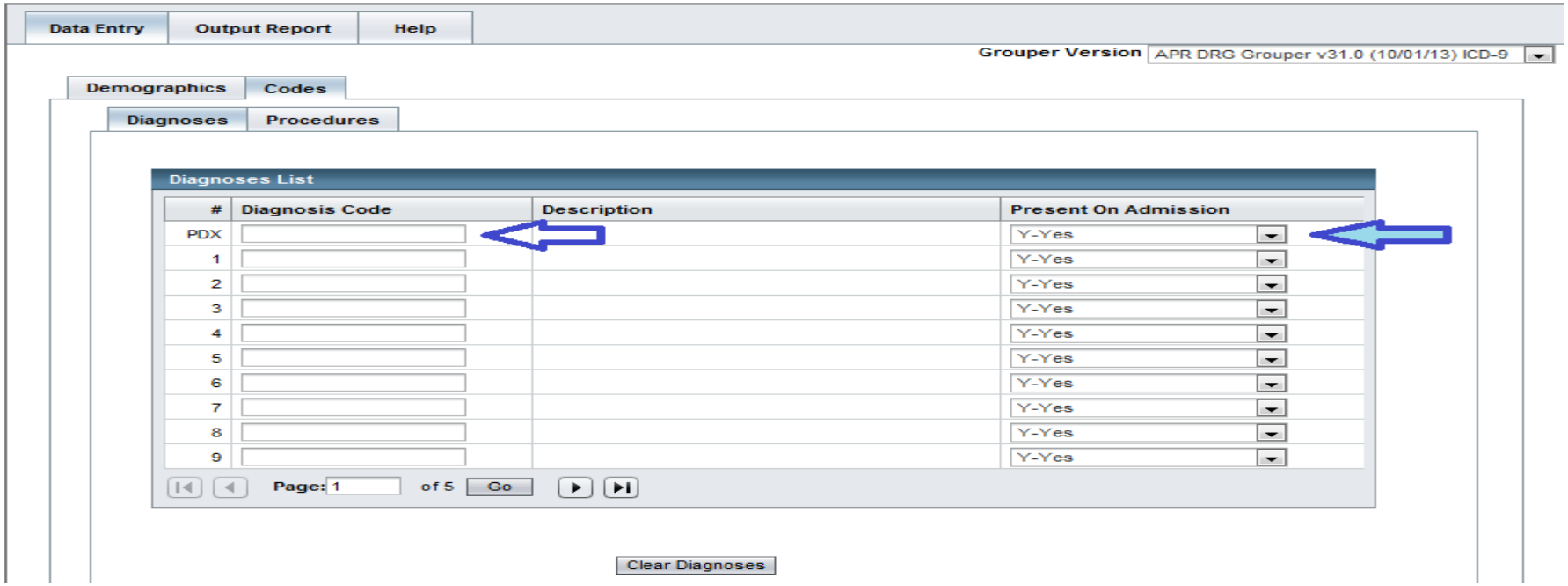
8. **Birth Weight (Grams)* – Enter weight of newborn in grams.**

***Fields 7 and 8 only needs to be fill in if you are trying to determine the DRG code on a newborn claims.**

APR DRG

3M Health Information Systems - Data Entry Tab – Codes

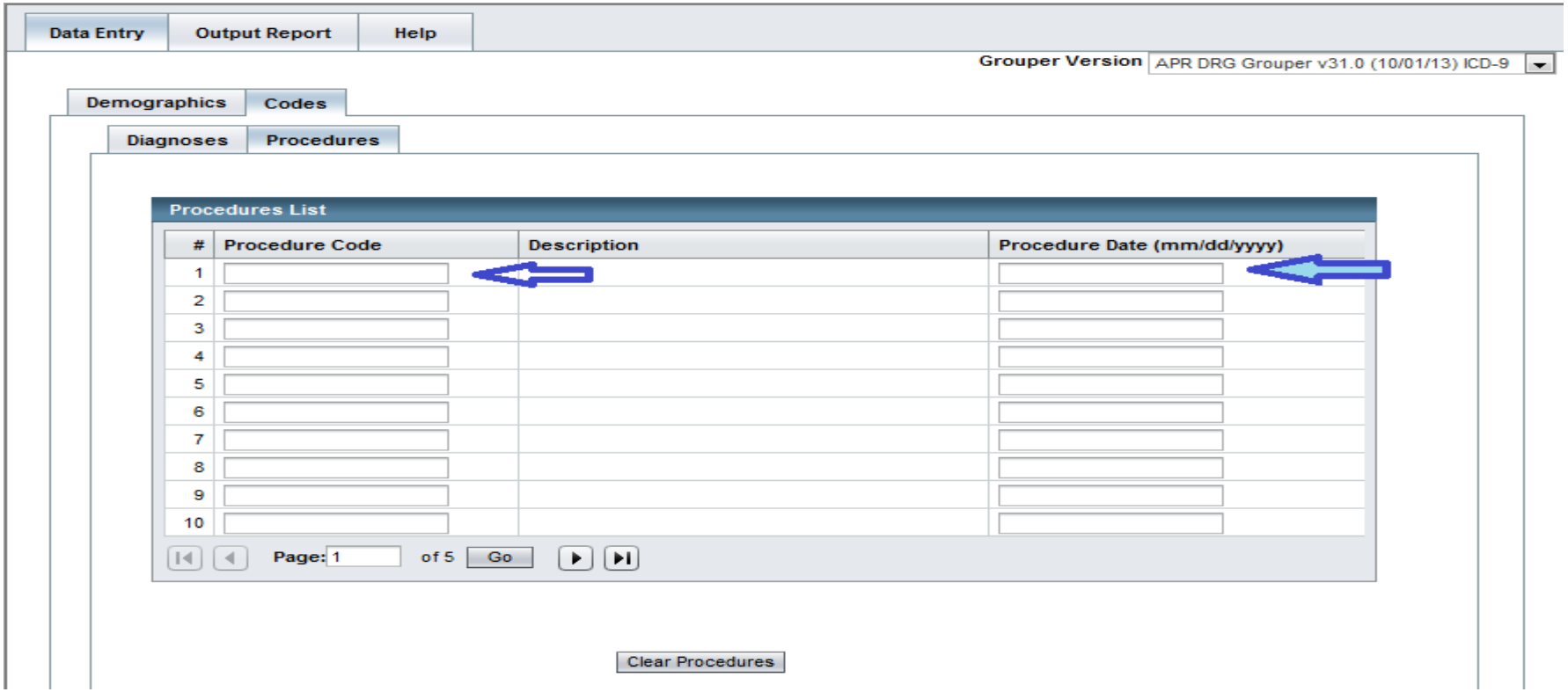
- **Diagnoses**



APR DRG

3M Health Information Systems - Data Entry Tab – Codes

- **Procedures**



APR DRG

3M Health Information Systems – Output Report

Once all information has been entered, under the “Output Report” tab, click on “Download Report” to get the report on your request which will include the APR DRG and SOI code for the inpatient stay.

APR DRG

Output Report – Identifying DRG and SOI code as 133-3. The inpatient claim will process based on DRG code 1333

3M Health Information Systems

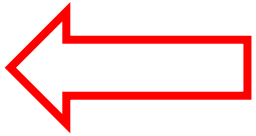
3M™ APR DRG Assignment Report

APR DRG Version 34.0

Patient ID :	*Not entered*	**Sex :**	Male
Age in Years :	64	**Status :**	1 - Home
Days Mech Vent (DMV) :		**DMV Source :**	6 - No DMV

Grouper Results for Admission APR DRG

MDC:	4 - RESPIRATORY SYSTEM
All Patient Refined DRG :	133 - RESPIRATORY FAILURE
Severity of Illness :	3 - Major Patient Severity of Illness
Risk of Mortality :	2 - Moderate Patient Risk of Mortality
Medical/Surgical DRG :	Medical
Return Code :	0 - DRG assigned



Hospital Modernization - DRG

Once the 3M tool sets a DRG code 1333, the hospitals can use the interactive DRG calculator to see what the DRG payment amount is on their inpatient claim.

- **The interactive DRG calculator is available on the hospital modernization page on the www.ctdssmap.com Web page.**

- **If the 3M tool returns with DRG code 956 “Ungroupable”, it means the DRG could not be determined based on the information on the inpatient claim.**
  - **The inpatient claim will deny with EOB code 0691 “DRG – Ungroupable”.**

If the hospital is questioning the DRG code or payment on their inpatient claim they can e-mail their questions to the Hospital Modernization APR or DRG questions e-mail address ctxixhosppay@dxc.com with a screen shot of the results from the 3M tool or DRG calculator.

Hospital Modernization - DRG

Interactive DRG Pricing Calculator

- **Each field is defined under the Calculator Instructions, but the fields highlighted in green are required to be entered by the user.**
  - **Submitted Charges – UB-04 field locator 47.**
  - **Non-covered Charges – UB-04 field locator 48. This would include charges for non-covered days.**
  - **Length of Stay – This is used in pricing transfer stays or partial eligibility.**
    - **The length of stay equals discharge date minus admit date, unless the discharge date equals the admit date, in which case length of stay is 1.**
      - **Inpatient stay admitted on January 11, 2018 and discharged on January 21, 2018, the hospital would enter 10.**

Hospital Modernization - DRG

- If the stay is for a transfer claim, the length of stay will equal discharge date minus admit date plus one day.
  - Inpatient stay admitted on January 11, 2018 and transferred on January 21, 2018, the hospital would enter 11.

- Client Eligible Days – Used for non-covered days adjustments. Enter the number of days the client is eligible during the stay, In most cases this will equal the full length of stay including transfer claims.

- Was patient transferred with discharge status = 02 or 05? - Enter Yes or No from the drop down box.

- Organ Acquisition Costs – If billing RCC 810-812, enter billed amount.

- Practitioners Costs – If the hospital bills 96X, 97X, 98X on the institutional claims instead of CMS-1500 the service will be denied on the claim and the hospital needs to enter the billed amount in this field.

Hospital Modernization - DRG

- **Third Party Liability (TPL) – Enter TPL payment.**

- **Provider AVRS ID – Select AVRS ID based on drop down list.**
  - **Provider Name – Auto-populated**
  - **Hospital Base Rate – Auto-populated**
  - **Hospital cost-to-charge ratio – Auto-populated**

Once you entered all the information, the DRG pricing calculator will estimate the APR DRG allowed amount (E45) and payment amount (E48).

Hospital Modernization - DRG

Example 1 – Inpatient stay admitted on January 11, 2018 and discharged on January 21, 2018 with a discharge status 01 for a female client 34 years old. Total charges $25,000, APR DRG 1393, APR DRG weight 0.9564, Average Length of Stay (ALOS) of 3.82, and DRG Outlier Threshold of $33,784.97. The Hospital base rate is $7,505.68 and Hospital cost-to-charge ratio is 0.32321.

- **APR DRG weight, ALOS and DRG Outlier Threshold amounts are found under the DRG Table CT on the DRG Pricing Calculator.**

Hospital Modernization - DRG

DRG Table CT - The "DRG Table CT" is the final tab under the DRG calculator that contains a list of the APR DRG codes and parameters used in pricing individual hospital inpatient stays. APR DRG codes, descriptions, national relative weights, and Average Lengths of Stay (ALOS) are determined by 3M Health Information Systems. The DRG Outlier Thresholds were developed specifically for CT through a rate setting process.

A	B	C	D	E	F	G	H
Connecticut Department of Social Services - Division of Health Services Inpatient DRGs Weights and Outlier Thresholds Under APR-DRG V35 Effective for Discharges 1/1/2018 and Forward							
This spreadsheet includes data obtained through the use of proprietary computer software created, owned and licensed by the 3M Company.							
All copyrights in and to the 3MTM Software are owned by 3M. All rights reserved.							
DRG	MDC	Description	Weight	ALOS	Outlier Threshold	Beginning Date	
1391	04	Other Pneumonia	0.4294	2.13	30,000.00	10/1/2017	12/31/2299
1392	04	Other Pneumonia	0.6051	2.60	30,000.00	10/1/2017	12/31/2299
1393	04	Other Pneumonia	0.9564	3.82	33,784.97	10/1/2017	12/31/2299
1394	04	Other Pneumonia	1.8720	6.52	68,219.59	10/1/2017	12/31/2299

Hospital Modernization - DRG

Connecticut Medical Assistance Program APR DRG Pricing Calculator

Effective for Discharges 01/01/2018 and Forward

Indicates data to be input by the user

Information	Data	Comments or Formula
INFORMATION FROM THE CLAIM		
Submitted charges	$25,000.00	UB-04 Field Locator 47.
Non-covered charges	$0.00	UB-04 Field Locator 48. For the purposes of calculating the outlier add-on payment, the non-covered charges must include a reduction for HCAC related charges.
Length of stay	10	Used for transfer pricing and non-covered days adjustments.
Client eligible days	10	Used for non-covered days adjustment.
Was patient transferred with discharge status = 02 or 05?	No	Used for transfer pricing adjustment.
Organ acquisition costs	$0.00	UB-04 Field Locator 47 for RCC 81X used for calculating outlier add-on.
Practitioner costs	$0.00	UB-04 Field Locator 47 for RCC 96X, 97X and 98X used for calculating outliner add-on.
Third Party Liability	$0.00	UB-04 Field Locator 54 for payments by third parties.
Provider AVRS ID	008055460	Select AVRS ID. Out of state and border status hospitals should select AVRS ID 008055460.
Provider name	Out of State/Border Status Hospital	Look up from Provider table.
APR DRG INFORMATION		
APR DRG	1393	From 3M-PC software version 35.
APR DRG description	Other Pneumonia	Look up from DRG table.
APR DRG weight	0.9564	Look up from DRG table.
Average length of stay for this APR DRG	3.82	Look up from DRG table.
HOSPITAL INFORMATION		
Hospital base rate	$7,505.68	Look up from Provider table. The hospital base rate is used to determine APR DRG base payment.
Hospital cost-to-charge ratio	0.32321	Look up from Provider table. Hospital cost-to-charge ratio used to estimate the hospital's cost of this stay in order to determine outlier add-on.

Hospital Modernization - DRG

PAYMENT POLICY PARAMETERS SET BY DSS		
DRG outlier threshold	$33,784.97	Look up from DRG table.
Outlier payment percentage	75%	Used for cost outlier adjustments.
APR DRG BASE PAYMENT		
Pre-transfer APR DRG base payment	$7,178.43	E23*E20
TRANSFER PAYMENT ADJUSTMENT		
Is a transfer adjustment potentially applicable?	No	E11
Transfer base payment	N/A	IF(E31="Yes",(E29/E21)*(E9+1), else "N/A")
Is transfer base payment < pre-transfer base payment?	N/A	IF(E31="Yes",IF(E32<E29,"Yes", else "No"), else "N/A")
Full Stay APR DRG base payment	$7,178.43	IF(E33="Yes",E32, else E29)
OUTLIER ADD-ON DETERMINATION		
Hospital specific estimated cost of the stay	$8,080.25	(E7-E8-E12-E13) * E24
Does this claim require an outlier payment?	No	IF E26 > E36 "No", Else "Yes"
Cost outlier payment	$0.00	IF E37 = "Yes" (E36 - E26) * E27, Else 0
NON-COVERED PAYMENT ADJUSTMENT		
Are covered days less than length of stay	No	IF E10 < E9 "Yes", Else "No"
Non-covered day reduction factor	1.000000	IF E40 = "Yes", (E10/E9)) Else 1.0
Non-covered adjusted APR DRG base payment	$7,178.43	IF E40 = "Yes", IF(E31="Yes",(E29/E21)*(E10+1),((E10/E9)*E29)) else E34
Non-covered adjusted outlier payment	$0.00	E38 * E41
CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT		
APR DRG allowed amount	$7,178.43	IF(E42>E29,E29+E43,E42+E43)
Does the charge cap apply?	No	IF E45 > E7 "Yes", Else "No"
Third Party Liability	$0.00	E14
Payment amount	**$7,178.43**	IF E46="Yes", then (E7-E47), Else (E45-E47) This will not include payment made for organ acquisition which is paid outside of the DRG payment methodology
CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.		

Payment Amount is $7,178.43. (The hospital claim payment will not exceed the total billed amount of the claim)

- **EOB code 8600 “Reimbursed via DRG Pricing” will post to claims that pay at DRG pricing.**

Timely Filing

Timely Filing Limitations - For HUSKY C and D clients for medical, dental, or behavioral health services and HUSKY A and HUSKY B for non-behavioral health services

- **Timely filing guidelines are one (1) year from the date of service.**

Waive Timely Filing Limit – Remittance Advice

- **Hospital have one (1) year from the date of the most recent RA indicating a denied to resubmit the claim, provided the denial was not for timely filing.**
- **Hospital have one (1) year from the date of the most recent RA when claim was paid to adjust the claim.**

Waive Timely Filing Limit – Third Party Liability

- **The date of service on the claim must fall within one (1) year of the issue date on the other insurance denial, providing the denial was not for timely filing.**

Client's Eligibility

- **The hospital has one (1) year from the date the client's eligibility was added to the eligibility file to submit the claim.**

Timely Filing

Timely Filing Limitations – Same rules apply for behavioral health services for HUSKY A and HUSKY B client, but the timely filing guidelines is 120 days.

Providers are no longer required to submit claims on paper that exceed timely filing when documentation exists that waive the timely filing limit, such as an RA, other insurance carrier's Explanation of Benefits (EOB), or Explanation of Medicare Benefits (EOMB).

- **DXC Technology will validate that the condition exists to override timely filing via the data submitted on the claim and the provider's past claim submission history.**

- **If the hospital needs to submit late changes, 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 this case 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 additional timely filing guidelines, hospitals can refer to Provider Manual Chapter 5 "Claim Submission Information."**

Frequent Claim Denial

Provider Manual Chapter 12 – Claim Resolution Guide

- **Explanation of Benefit (EOB) codes for hospital modernization were added to provider manual chapter 12.**

- **The provider manual will provide a detailed description of the cause of each EOB and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition.**

- **This guide also provides tips by identifying where providers can go to find additional information to assist with correcting their claims.**

Frequent Claim Denial

EOB code 0305 “APC - Medical visit on same day as type T or S procedure w/o modifier 25 - significant separate E&M service"

Cause

- **A clinic or emergency department visit (status indicator V-clinic or emergency department visit paid under OPPS) has been billed without modifier 25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the same date of service as a significant procedure (status indicator S or T Significant Procedure payable under OPPS).**

Resolution

- **Correct the claim by adding modifier 25. Re-submit the claim. If there is already a modifier 27 on that detail, add the modifier 25 in the 2nd position.**

Frequent Claim Denial

EOB code 0316 “APC - Only incidental services reported"

Cause

- **The outpatient claim was submitted with only incidental services being billed.**

Resolution

- **Please verify the procedures submitted on the claim. If an outpatient claim was submitted without an APC payable service and just packaged services will be denied.**

Frequent Claim Denial

EOB code 0337 “APC – Total Allowed Amount on APC Claim is Zero.”

Cause

- **The outpatient claim was billed with an APC payable procedure code that was denied with a different EOB code causing there to be no APC payable allowed amount on the claim.**

Resolution

- **Please review the other EOB code setting on the APC payable procedure code and, once you resolve that EOB, it should resolve EOB 0337 at the same time.**

Example:

- **Outpatient claim denies with EOB 0337, but one of the details is also denying with EOB 0856 “Required Operating Provider Number is Missing”. If the hospital adds the operating provider number to the claim and re-submits the claim, the claim could process without denying for EOB 0337.**

Frequent Claim Denial

EOB code 0878 “Allowed Amount is Zero Manual Priced Outpatient APC, Provider Fee Schedule, if Not Outpt Contact PAC”

Cause

- **Outpatient APC claim with details with Status Indicator (SI) equal to “Q1, Q2, Q3 or Q4” on a manually priced claim with a detail with SI “C”, payment rate “MP” and payment type “Surg”.**

Resolution

- **Details with SI “Q1 - Q4” will be included in the manually priced amount and will not allow any additional reimbursement. Please verify detail with SI “C” for manually priced allowance.**

Frequent Claim Denial

EOB code 5025 “APC duplicate claim – APC Service must be on same claim for Date of Service”

Cause

- **The outpatient claim denied because another claim for the same client on the same date of service was paid previously and it contained an APC payable code.**

Resolution

- **Hospitals should bill all outpatient services for a single date of service on one claim to process using CMAP OPPS methodology. Exception: Multiple Outpatient Hospital E/M Encounters on the Same Date can be billed on a different claim.**

- **Hospital can use the claim inquiry on the Web site to find the duplicate outpatient claim. They should not be contacting PAC or e-mailing the ctxixhosppay@dxc.com to do a claim inquiry for the hospital.**

***When performing a claim inquiry, do not just search for the date of service of the denied claim, extend the FDOS and TDOS to capture all outpatient claims.**

Hospital Modernization Page

Comprehensive information on CT OPPS can be found on the "Hospital Modernization" page on the Web site www.ctdssmap.com. Please refer to this page often, as this will be continue to be updated throughout the year.

- **Important Messages – Connecticut Hospital Modernization**
  - **Hospital Monthly Important Messages**
  - **Current CMAP Addendum B**
  - **Prior Authorization Grid for Outpatient Hospitals**
  - **Provider Type and Specialty to Revenue Center Code Crosswalk**

- **DRG Calculator**
  - **DRG Calculator (For Discharges Dates 1/1/2018 and Forward)**
  - **DRG Calculator Historical Versions**

Hospital Modernization Page

- **Hospital Outpatient Payment Methodology - Ambulatory Payment Classification (APC)**
  - **Outpatient Hospital Modernization FAQ**
  - **CMAP Addendum B PDF**
  - **CMAP Addendum B Changes and Historical Versions**

- **Helpful Information & Publications**
  - **Provider Bulletins and Policy Transmittals**
  - **Provider Training**
    - **Workshop Materials**
  - **Provider Manuals**
  - **HUSKY Health Benefit Grid**
    - **Prior Authorization**
  - **CT BHP Authorization Schedule**
  - **CT Provider Fee Schedule**

Training Session Wrap Up

- **Provider Manual Chapter 5 – Claim Submission Information for information on timely filing guidelines, how to correct or update Third Party Liability (TPL) information on a client's file and Remittance Advice (RA) information.**

- **Provider Manual Chapter 8 - Provider Specific Claims Submission Instructions is located on the www.ctdssmap.com Web site; under publications, scroll to provider manual chapter 8 and from the drop down select the provider type.**

- **Provider Manual Chapter 12 – Claim Resolution Guide will provide a detailed description of the cause of each EOB and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition.**

- **Hospital Modernization e-mail address (only APC or DRG questions only) ctxixhosppay@dxc.com.**

- **Provider Assistance Center (PAC): Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays at 1-800-842-8440.**

Time for Questions

Questions & Answers

Thank you.