# Connecticut Medical Assistance Program

## Hospice Refresher Workshop

Presented by
The Department of Social Services
& HP Enterprise Services

# Training Topics

- What's New in 2015?
  - Electronic Messaging
  - Claim Adjustments
  - Messages Archived
- Proposed  Changes in Hospice Rates Fiscal Year 2016
- Client Eligibility - Determining the Hospice Benefit
- On-line Hospice Transactions
  - Locking in the Hospice Benefit/Managing the Hospice Lock-in
- Covered Services/Non-Covered Services/Claim Submission Guidelines
- Prior Authorization Requirements
- Patient Liability
- Claim Denials and Resolution
- Hospice Reminders
- ICD-10 Readiness
- Program Resources/Contacts/Questions

# Electronic Messaging

The Department of Social Services (DSS) and HP are pleased to announce the implementation of electronic messages replacing the mailing of bulletin/policy transmittals

Provider Bulletin 2015-23 “Implementation of Electronic Messaging - Replacement to the Mailing of Bulletins/Policy Transmittals”

Hospice providers and their office staff can subscribe to receive pertinent CMAP program information via e-mail messages

DSS and HP no longer distributes any paper communications to providers as of June 30, 2015

# Electronic Messaging

**DSS and HP will use electronic messaging to distribute:**

- Provider bulletins and policy transmittals
- Workshop invitations
- Program updates and reminders

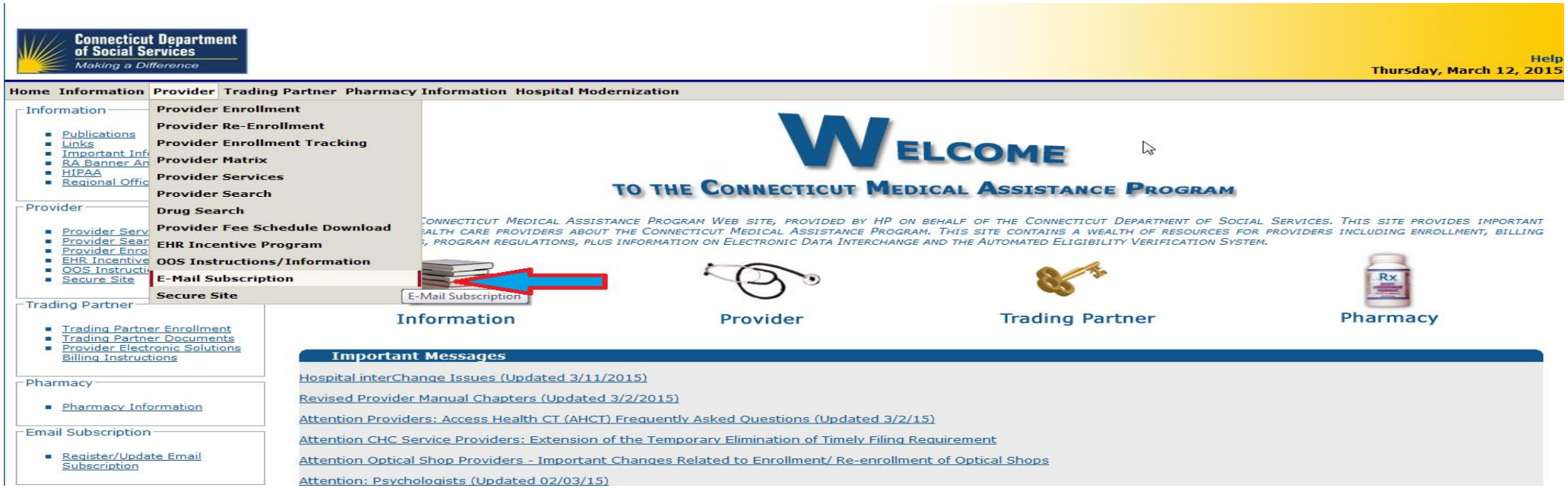
**There are many benefits to the electronic delivery of communication**

- Faster distribution of information to the provider community
- Any office personnel can subscribe to receive program information via e-mail.
- Provides a simplified subscription process that can be completed very quickly allowing information to get into the right hands

# Electronic Messaging

**To subscribe for electronic messaging, providers and office staff must perform the following steps:**

- Access the www.ctdssmap.com Web site.
- Select Provider > E-mail Subscription from the drop-down menu.

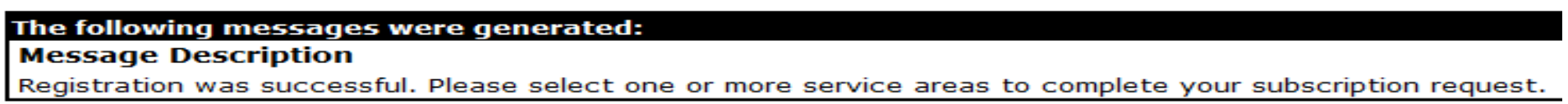


# Electronic Messaging

➢Once on the E-mail Subscription page, enter the e-mail address you wish to subscribe under New Subscriber.

➢Re-enter the e-mail address for verification and click Register

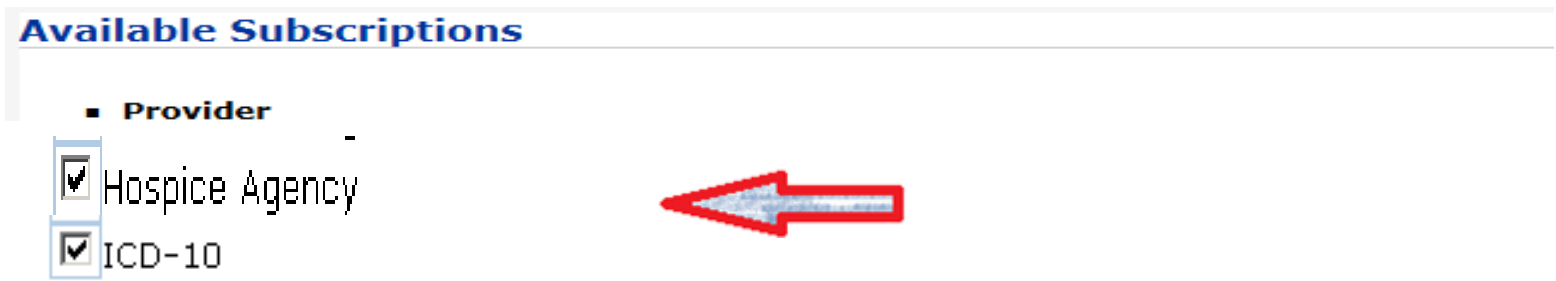

- A confirmation message will be displayed at the top of the page




- If you receive an error message, correct the error(s) and click **Register** again

# Electronic Messaging

- From the right hand side of the page, use the checkboxes to select the available subscriptions you would like to receive




- Once complete, select Save

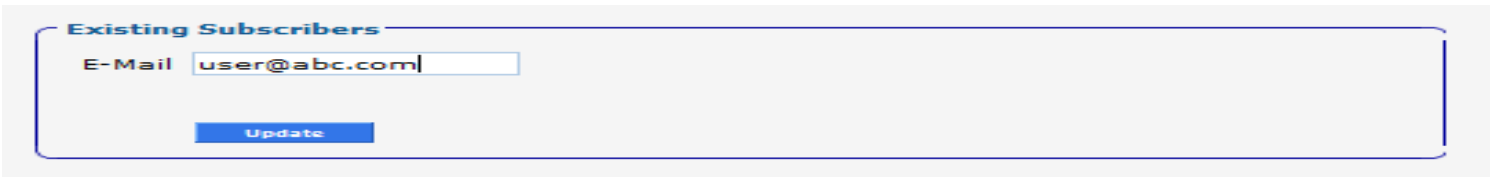
# Electronic Messaging

- **Providers that supplied e-mail addresses at the time of enrollment or re-enrollment in CMAP, or during the setup of their Secure Web portal account, will automatically be subscribed for e-mail notifications**
  - Please note that the email addresses on file for clerk accounts will not be included in the auto-subscribe process and will need to subscribe separately

- **Once you have subscribed, you may modify your subscriptions at any time by performing the following steps**
  - Access the www.ctdssmap.com Web site
  - Select Provider > E-mail Subscription from the drop-down menu

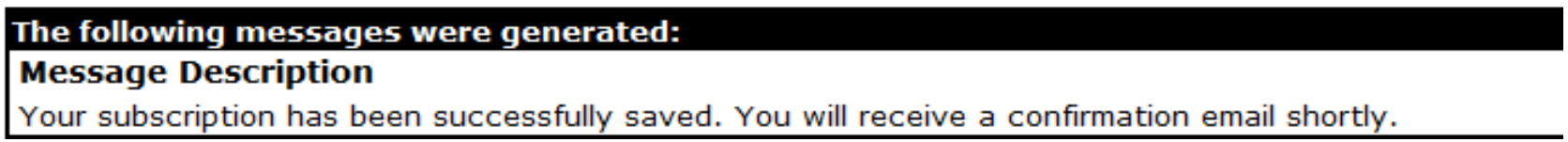
# Electronic Messaging

Once on the E-mail Subscription page, enter the e-mail address you wish to modify in the Existing Subscribers section of the panel and click Update



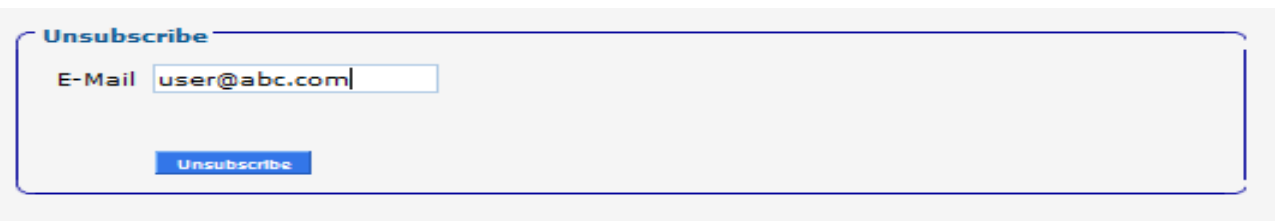

From the right hand side of the page, use the checkboxes to modify your subscriptions and click Save

Once you have successfully modified your subscriptions, you will receive a confirmation notice that includes the provider type(s) and/or topic(s) you selected from the checkboxes

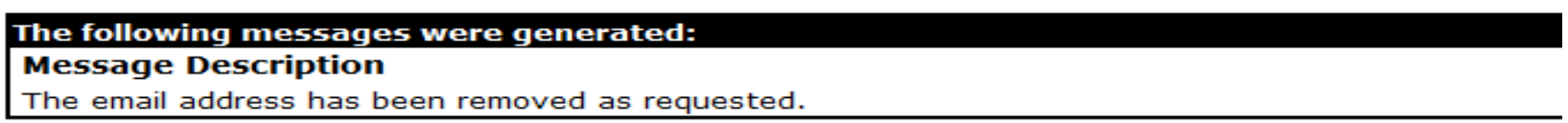


# Electronic Messaging

- To **Unsubscribe** your subscription, you will need to do the following steps:
  - Access the www.ctdssmap.com Web site
  - Select Provider > E-mail Subscription from the drop-down menu
  - Once on the E-mail Subscription page, enter the e-mail address you wish to unsubscribe in the Unsubscribe section of the panel. Once complete, click Unsubscribe




  - A confirmation message will be displayed at the top of the page



# Claim Adjustments

## Timely filing changes to claim adjustments:

Effective **June 2, 2015**, when a **non-crossover claim** adjustment is submitted to pay the same or less than the original claim, DSS has approved the bypass of timely filing edits for claims with a date of service or last paid date over the timely filing limit (one year)

Providers may now submit these types of adjustments via the web or 837 adjustment transaction

Providers no loner need to:

- Submit paper Paid Claim Adjustment Forms (PCARS) for said adjustments
- Submit a check to give back an overpayment

# Messages Archived

**DSS and HP has started archiving RA Banner and Important Messages on the www.ctdssmap.com Web site. To access archived messages, nursing home and ICF/IID providers will need to access the Messages Archived page by selecting Messages Archived from the Information drop-down menu on the home page. RA Banner and Important Messages dated January 1, 2014 and forward will be saved on the Web site and be available for review.**

# Proposed  Changes in Hospice Rates Fiscal Year (FY) 2016

## Market Basket Increase:

- CMS announced in the FY2016 a proposed rule that the proposed hospice payment increase for FY2016 would be 1.8%. The 1.8% increase is after the 0.6 and 0.3 productivity factors have been deducted

## Tiered Routine Home Care Rate:

- CMS announced a proposal  to establish two tiers of routine home care payments, one payment for days 1 – 60 and a reduced payment for days 61 +

## Service Intensity Add-on:

- CMS announced a proposal to establish a service intensity add-on for patients in the last seven (7) days of life. The rate is proposed to be established at the hourly continuous home care rate

***Stay tuned! Watch for upcoming announcements***

# Client Eligibility Verification

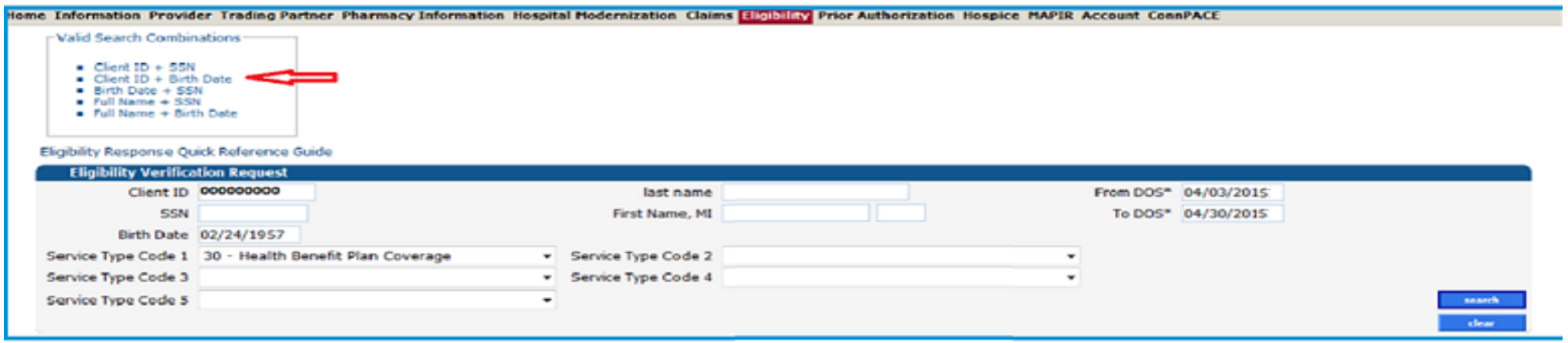
- **DSS recommends that providers verify a client's eligibility on the date of service prior to performing the service as eligibility can change at any time**

- **To determine if a client is eligible for the Hospice benefit, providers may use any of the available methods of checking client eligibility:**

  - Provider Secure Web site at www.ctdssmap.com
  - Provider Electronic Solutions Software
  - HIPAA ASC X12N 270/271 Health Care Eligibility Inquiry and Response
  - Automated Voice Response System (AVRS)

# Client Eligibility Verification

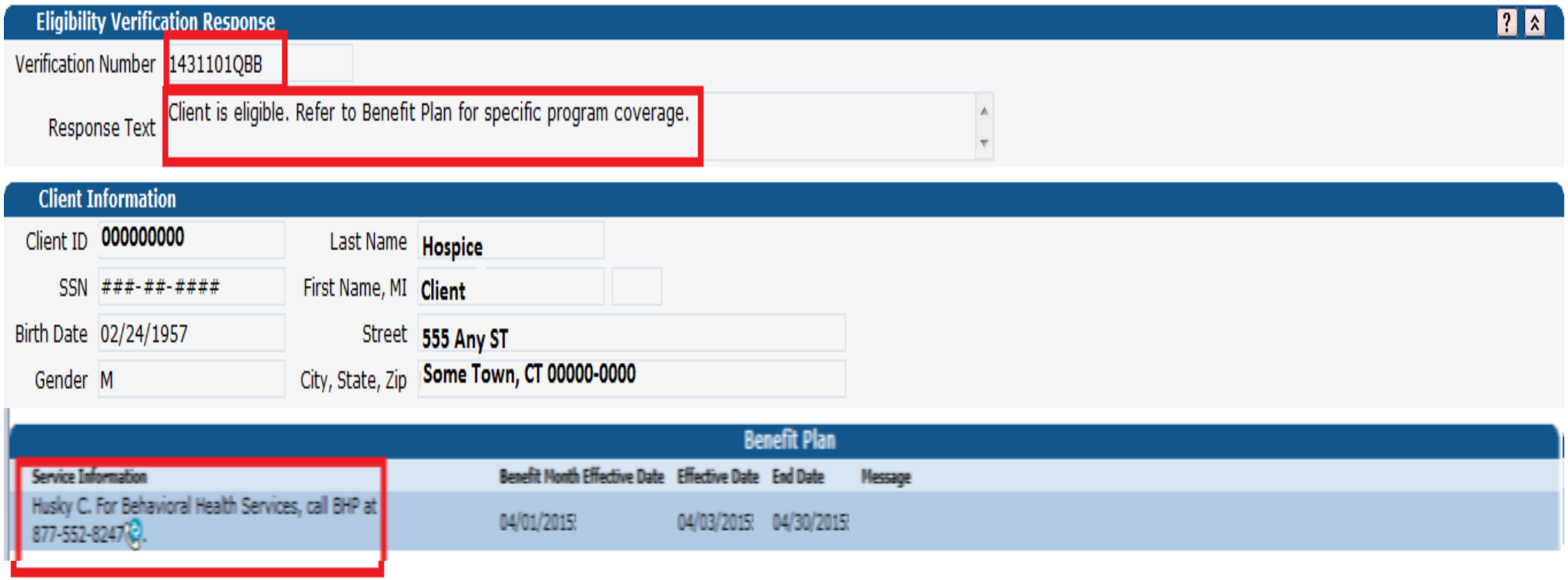
- To verify a CMAP client's eligibility through the secure site – click on the ***Eligibility tab*** on the main menu
- Enter enough date to satisfy a least one of the valid search combinations; click search
- Enter a ***valid client data search combination*** as noted below, then click search




- When entering a client's full name as part of your search criteria, the client's name must be entered as it appears in their CTMAP profile

# Client Eligibility Verification

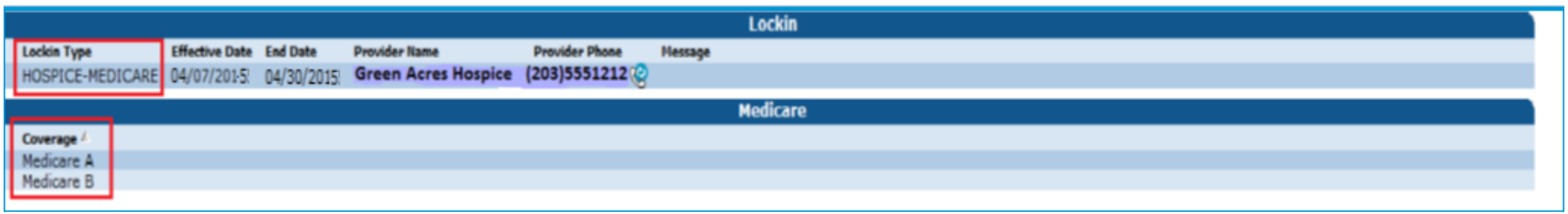
- The Verification Number validates the eligibility information received during the inquiry
- Clients with HUSKY A, B, C and D coverage are eligible for Hospice Services



# Client Eligibility Verification

## Client eligibility information on the Web will include:

- Services restricted to or lock-in to ***"Hospice"*** or ***"Hospice Medicare"***, if the client is eligible for Medicare
- Name of the hospice provider
- The effective and end dates of the hospice coverage based on the dates of service submitted in the eligibility request
- The telephone number of the hospice provider



# Hospice Eligibility

## A client is eligible to receive the hospice benefit when:

- The client is certified by a physician as being terminally ill
- Initial certification is 90 days
- Recertification is for a second 90 day period followed by unlimited 60 day periods

## The client will be locked into service by a single hospice agency for services relating to their terminal illness for the duration of the certification period

- A client may change hospice agencies once during this period under **Medicare**, **no limit** for **Medicaid**
- A client may choose to revoke election of hospice services at any time
- A client may re-elect the hospice benefit at any time

## Clients that are eligible for both Medicare A and Medicaid receive hospice services through Medicare

- When a dually eligible client decides to elect, revoke, or change hospice providers, they must make such elections, revocations, and changes in both the Medicare and Medicaid programs

# Locking in the Hospice Benefit

- **All clients who elect the Hospice benefit:**
  - **Dually Eligible**
  - **HUSKY Only**

***Must*** be locked into the care of the Hospice provider during the course of their election in order for the Hospice provider to be paid for the service billed

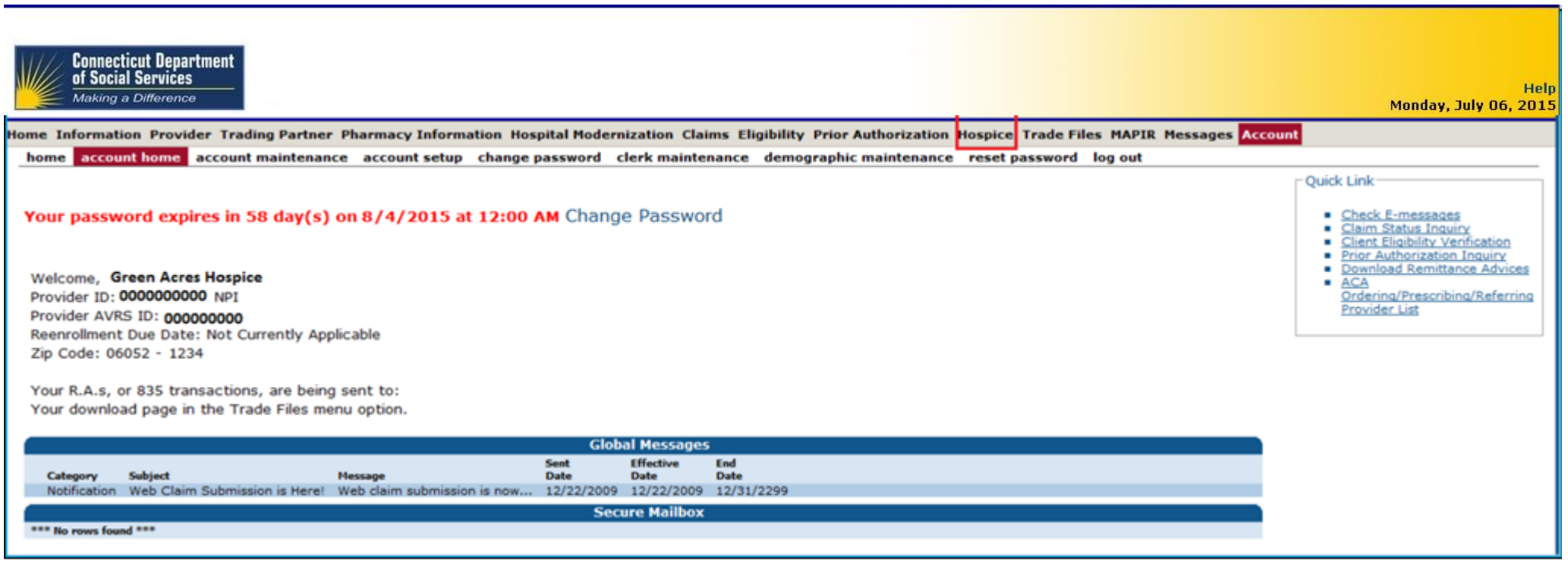
- The Hospice Provider **must** enter an *Election Transaction* via their secure Web Account within seven (7) business days of the effective date of the hospice election
- When a client is pending HUSKY eligibility, the Hospice Provider **must** enter an *Election Transaction* via their secure Web Account *within seven (7) business days* of the client's eligibility being added to the Department of Social Services client eligibility file

# On-line Hospice Transactions – *Locking in the Hospice Benefit*

**To enter a *Hospice Election Transaction*, providers must log into their secure web account from the *www.ctdssmap.com* Home Page and click *"Secure Site"***

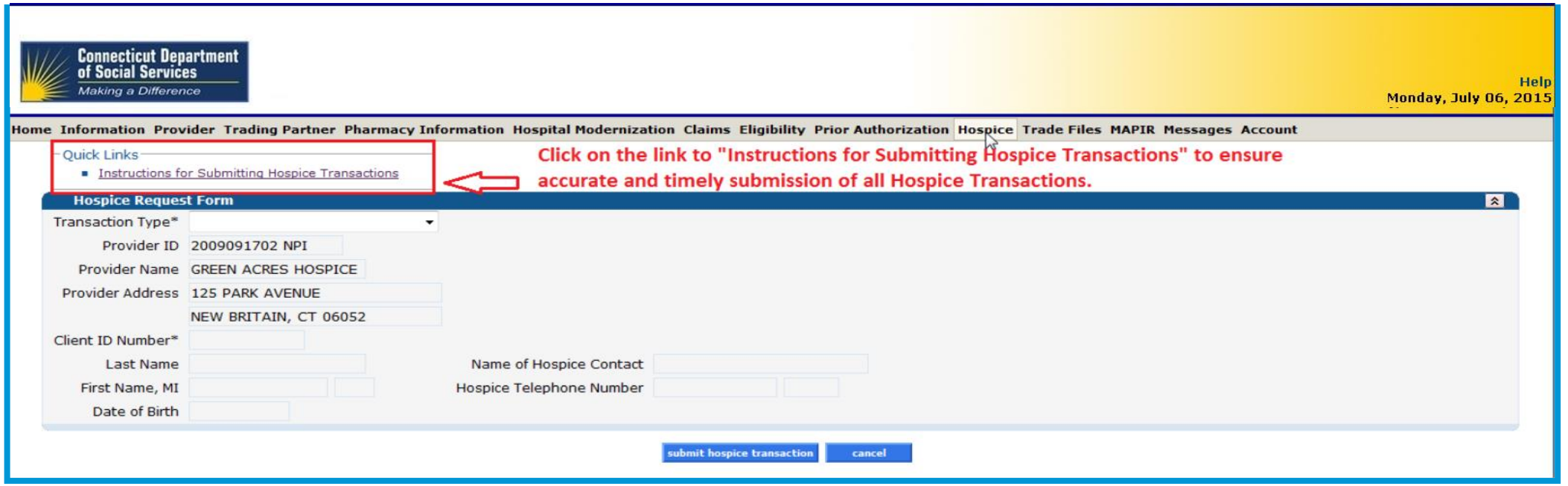
# On-line Hospice Transactions – *Locking in the Hospice Benefit*

## From the provider's secure Web account Home Page, click "Hospice"



# On-line Hospice Transactions – *Locking in the Hospice Benefit*

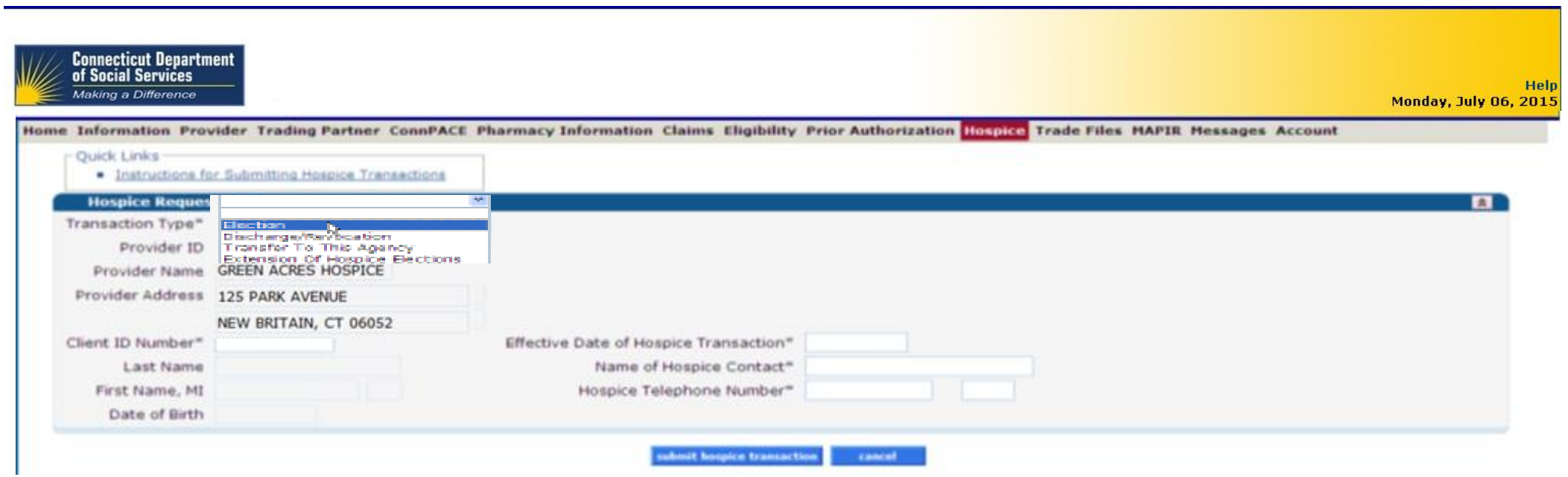
**The *"Instructions for Submitting Hospice Transactions"* provides step by step instructions for submitting all Hospice Transactions, including important filing requirements**




***Note:*** **If you are logged in under another secure Web account, such as your Home Health Agency or Assisted Living Services Agency secure Web account, a message "Hospice election requests can only be sent by Hospice providers", indicating you are logged into the incorrect account**

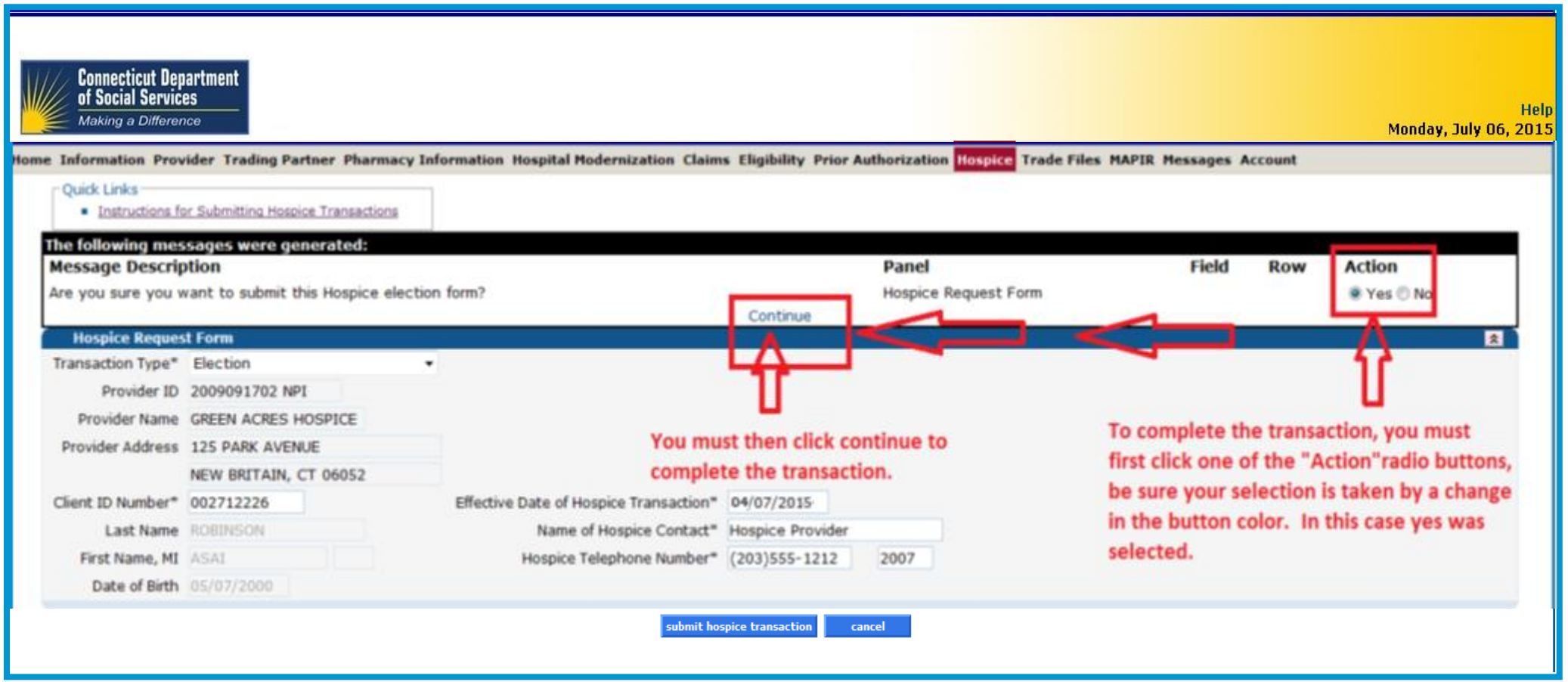
# On-line Hospice Transactions – *Locking in the Hospice Benefit*

**To submit a *"Hospice Election",* click on *"election"* from the dropdown, complete the transaction fields that have an asterisk and click *"Submit Hospice Transaction"***



# On-line Hospice Transactions – *Locking in the Hospice Benefit*

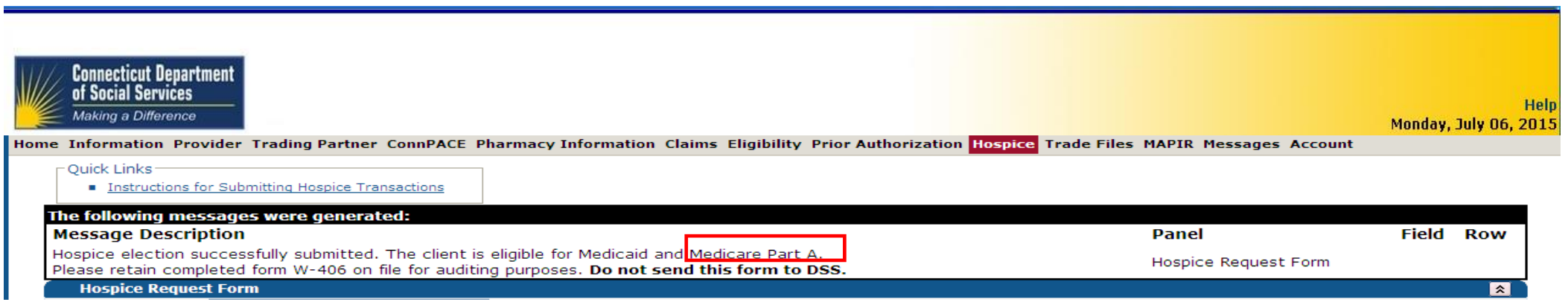
Once you confirm that you want to submit the election click ***"Continue"***



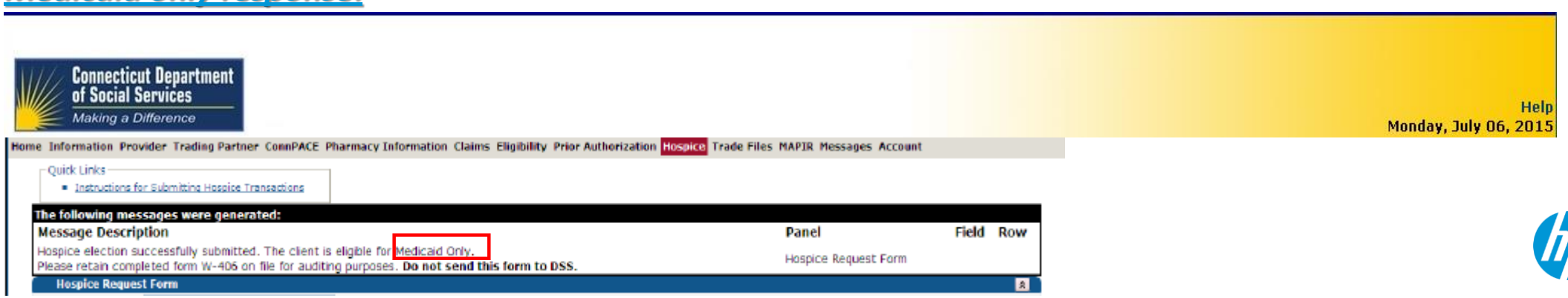
# On-line Hospice Transactions – *Locking in the Hospice Benefit*

Once you click *"Continue,"* you will receive a *confirmation message* that your transaction was *successfully submitted*

## *Dual Eligible response:*




## *Medicaid only response:*



# Hospice Election Transaction

## *Managing the Hospice Lock-in*

**Important Points to Remember:**

- **A Hospice Election Transaction must be submitted by the Hospice Agency within seven (7) days when:**
  - A client initially elects the hospice benefit
  - Re-elects the benefit after revocation
  - Re-elects the benefit after discharging from the care of another Hospice Agency or your own Agency

- **Submission of the "Election Transaction" does not immediately place the lock-in on the client's eligibility file. This may take up to fourteen (14) business days to be updated**
  - Updates to the Election Transaction can be made up until the transaction appears on the eligibility file
  - The lock-in, when entered on the client eligibility file will be for a period of one year

# Hospice Election Transaction

## *Managing the Hospice Lock-in*

**Important Points to Remember:**

- Failure to submit the **Election Transaction within seven (7) business days of the effective date of the hospice election,** may result in **lost hospice lock-in days** with the effective date of the transaction; providers will have to use the first day the on-line transaction tool will allow
- If the Notice of Election **(NOE)** is **not filed** in a **timely** matter, the hospice provider **will only be allowed to enter an election transaction retroactively up to seven (7) business days**
- Providers should **confirm accurate entry of the Hospice election** by checking client eligibility and Hospice agency provider ID
- The Hospice provider cannot bill the beneficiary for non-covered days and the Hospice provider will be liable for the non-covered days
- **Hospice Election Forms should not be sent to DSS.** They should be retained by the provider for audit purposes

# Hospice Election Transaction

## *Managing the Hospice Lock-in*

### Important Points to Remember:

Once the Hospice lock-in has been entered on the client's eligibility file, it is the **Hospice Provider's responsibility to maintain the lock-in** as applicable to the client's treatment and requests as defined in the Hospice Regulations by submitting the appropriate on-line transactions in a timely manner:

- Discharge/Revocation
- Transfer to another Hospice Agency
- Extension of the Hospice Lock-in

# Hospice Discharge Transaction

## *Managing the Hospice Lock-in*

**Important Points to Remember:**

- Discharges **should be entered timely** to update the lock-in as soon as possible to avoid delay in entering additional transactions or delaying treatment by other providers in the care of a client. Discharges may be updated until the discharge transaction appears on the eligibility file
- Submission of the discharge transaction does not automatically update the lock-in on the client's eligibility file. **Entry of the transaction may take up to fourteen (14) business days**
- Each revocation must be entered as a discharge
- A new election cannot be entered until the discharge transaction has been entered and the client's eligibility file updated

# Hospice Discharge Transaction

## *Managing the Hospice Lock-in*

**Important Points to Remember:**

- A **discharge should not be entered** if a client is being directly transferred to another Hospice Agency. An automatic discharge will be entered upon receipt of the transfer by the receiving Hospice Agency
- The **discharge form, W-404**, or **revocation form, W405, should not be sent to DSS** unless the reason for discharge is:
  - ✓ Just cause **(discharge code 5)**

**This reason for discharge requires DSS approval. Form W-404 must be faxed to (860) 424-5799**

# Hospice Transfer Transaction

## *Managing the Hospice Lock-in*

### Important Points to Remember:

- A transfer transaction is entered by the Hospice Agency directly receiving a client from another Hospice Agency
- A transfer transaction may be **submitted up to 3 days prior to the transfer date or 3 days after the transfer date**
- Submission of the transfer transaction does not automatically update the lock-in on the client's eligibility file. **Entry of the transaction may take up to fourteen (14) business days**
- Hospice transfer transactions may be updated until the transfer transaction appears on the eligibility file
- A discharge from the transferring Hospice will not occur until the transfer transaction is received by the receiving Hospice
- The Hospice Transfer form, W-403, **should not** be submitted to DSS

# Hospice Extension Transaction

***Managing the Hospice Lock-in***

**Important Points to Remember:**

- An **on-line extension** transaction is entered by a Hospice Agency to extend the lock-in of a client that will exceed the initial twelve (12) month election period or subsequent twelve (12) month extension period

- A Hospice extension may be **submitted up to 30 days prior to the end date of the most current hospice lock-in segment**

- A Hospice extension **cannot be submitted more than three (3) business days after the end date of the current Hospice segment**

- Submission of the extension transaction does not automatically update the lock-in on the client's eligibility file. **Entry of the transaction may take up to fourteen (14) business days**

# Covered Services – *RCC 651 – Level of Care*

## ➢ *RCC 651 – Hospice/RTN Home (Hospice HUSKY only)*

- All inclusive rate for all hospice related services to a client not in crisis performed in the home, nursing facility, hospital or ICF/IID

**Hospice provider can also bill the following revenue center codes on the same day:**

- ***RCC 658 Hospice Room and Board-Nursing Facility***
  - If care is provided in the nursing facility
- ***RCC 657 Hospice/Physician***

# Covered Services - *RCC 652 – Level of Care*

## ➢ *RCC 652- Hospice/CTNS Home (Hospice HUSKY only)*

- All inclusive per hour rate for hospice related services to a client during brief periods of crisis, provided in the home. A minimum of 8 hours of care must be billed per day

**Hospice provider can also bill the following revenue center codes on the same day:**

- *RCC 657 Hospice/Physician*

# Covered Services - *RCC 655 – Level of Care*

➢ ***RCC 655 – Hospice/IP Respite (Hospice Dually Eligible or Hospice HUSKY)***

- All inclusive rate for all hospice related services performed in the Nursing Facility or other location in order to give the caregiver a rest
- Only 5 days of respite care in a Nursing Facility or other location is allowed within a 60 day period
- RCC cannot be billed for clients who reside in a Nursing Facility, the client must be residing in the community

**Hospice provider can also bill the following revenue center code on the same day:**

- ***RCC 657 Hospice/Physician***

# Covered Services - *RCC 656 – Level of Care*

- ***RCC 656 – Hospice/IP Non-Respite Care in Nursing Facility or Hospital (Hospice HUSKY only)***

- All inclusive rate for all hospice related services performed in the Nursing Facility or Hospital when pain control or chronic symptoms cannot be managed in other settings

- Prior Authorization is required after 5 days of inpatient care

**Hospice provider can also bill the following revenue center code on the same day:**

- ***RCC 657 Hospice/Physician***

# Covered Services - *RCC 657 – Other Services billed by Hospice Providers*

- ***RCC 657 – Hospice/Physician billed by the Hospice Agency (Hospice HUSKY only & crossover claims)***

- **Must be billed with at least one procedure code per date of service**
  - By Physician employed by or contracted by the hospice
  - Service must be related to the terminal illness

- **Procedure codes in the 7xxxx range (radiology services-physician component) must be billed with modifier 26**
  - Explanation of Benefit (EOB) code 0707- Hospice Radiology Services require modifier)

**Hospice provider can also bill one of the following level of care revenue center codes, on the same day:**

- ***RCC 651 Hospice/RTN Home***
- ***RCC 652 Hospice/CTNS Home***
- ***RCC 655 Hospice/IP Respite***
- ***RCC 656 Hospice/IP Non-Respite***

# Covered Services - *RCC 658 – Other Services billed by Hospice Providers*

➢ ***RCC 658 – Hospice Room and Board - Nursing Facility (Hospice Dually Eligible or Hospice HUSKY)***

- Client must be **residing in a nursing facility** and have a **valid Nursing Facility "Level of Care" authorization segment** on their eligibility file

- Hospice provider **may also bill one of the following revenue center codes** on the same day for **Medicaid only clients:**

**Hospice provider can also bill the following revenue center codes, if applicable, on the same day:**

- ***RCC 651 Routine Care***
  - If care is provided in the Nursing Facility
- ***RCC 657 Hospice/Physician***

# Non Covered Hospice Services

- Reference section 17b-262-842 of the regulation
- These services are ***not covered*** when the client elects the hospice benefit
  - ✓ **Treatment to cure the illness**
    - **Except for children under the age of 21 (HUSKY A, C, and D)**
    - **Except for children under age 19 (HUSKY B)**
  - ✓ **Hospice services by more than one hospice provider**
  - ✓ **Drugs that are anti emetics and narcotic analgesics billed by pharmacy providers**

# Claim Submission Guidelines

**Hospice Claims can be submitted to HP via:**

- ✓ Web Claim Submission
- ✓ ASC X12N Health Care Claim Institutional Format
- ✓ Provider Electronic Solutions ***(may be used through September 30, 2015, if provider does not upgrade to version 3.81)***
- ✓ UB-04 Claim Form

**Providers should refer to:**

- **Chapter 8 - Hospice Claim Submission Instructions** located on the **www.dssmap.com** Web site click > publications > provider manuals > select Hospice in drop-down > view chapter 8

**Type of Bill:**

- 81X = Non Hospital Hospice Claim
- 82X = Hospital Hospice Claim

# Claim Submission Guidelines

- **Claims cannot span multiple calendar months**
- **Only one date of service allowed per claim detail**
- **Only one of the following four levels of care can be billed on a date of service:**
  - ✓ RCC 651 (Routine Care)
  - ✓ RCC 652 (Continuous Home Care)
  - ✓ RCC 655 (Respite Care in Nursing Facility or Hospital)
  - ✓ RCC 656 (General Inpatient Care in Nursing Facility or Hospital)

# Claim Submission Guidelines – *Nursing Facility (room/board)*

- **DSS will reimburse hospice providers at 95% of the nursing facility's per diem rate on file**
- **To secure an accurate reimbursement:**
  - Hospice clients may only be admitted to those facilities with which the hospice agency has a written agreement
  - A client who resides in a nursing facility must be authorized with a pay start of the institution in which they reside
  - Room and board charges are billed by and payable to the hospice agency only
  - Agency will submit a claim to HP for ***RCC 658***, DSS pays the hospice agency the room/board. The hospice agency must then reimburse the nursing facility

**Long term care providers may bill the Department of Social Services for hospital and home leave days for a hospice client *(RCCs 183, 185)***

# Prior Authorization

## ➢ Hospice Services Requiring Prior Authorization:

- **General Inpatient Care in a hospital or Nursing Facility which extends beyond the fifth day of care**
  - **HUSKY only clients:**
    - ✓ CHN PA request for Hospice Services
- **Hospice Care extending for more than 12 months**
  - **HUSKY only clients:**
    - ✓ complete on-line extension and
    - ✓ CHN PA request for Hospice Services
  - **Dually eligible clients:**
    - ✓ complete on-line extension
    - ✓ Retain the revised W-406 in the clients records Do not send to DSS

# Prior Authorization

**Prior authorization forms for the Authorization of Hospice Services are located online:**

**www.huskyhealth.com**

- Click "*For Providers*" → "*Provider Bulletins, Updates and Forms*" → "*Outpatient Authorization Request Form*"

- Authorization requests may be submitted to CHNCT via either:
  - ✓ *Clear Coverage* online portal **www.huskyhealth.com** click on "*For Providers*", then *"Access Clear Coverage"*
  - ✓ Fax: 203-265-3994

# Patient Liability

- **Patient Liability** represents the amount a client in a **Nursing Facility** is responsible to contribute toward their care each month

- If a claim is submitted where the patient liability exceeds the Medicaid allowed amount an A/R (accounts receivable) is created for the difference

- Patient liability amounts are calculated and determined by the DSS Regional offices based on the client's income (pension, SS, etc.) healthcare expenses

# Patient Liability

- **Patient liability is deducted from the first claim processed for the month in which patient liability is due**

For example:

- Client resides in a nursing facility
- From 11/1/14 – 11/5/14 the client is in the hospital
- On 11/5 the client returns to the nursing facility and elects the hospice benefit
- Nursing facility submits a claim for client's bed reserve 11/1/14-11/4/14
- The Hospice submits the nursing facility room and board for 11/5/14 - 11/30/14
- Patient liability is deducted from the first claim that processes; at the header of the claim, not the detail

- **Hospice agency and nursing facility providers need to make arrangements to reconcile patient liability**

# Patient Liability

- **Mass adjustments due to patient liability changes within clients' profiles will occur as those rates are often retroactively changed by DSS**

- Changes do not require claim adjustments to be performed by providers
- Patient Liability Mass adjustments are processed the first cycle of every month; adjustments will appear on RA with an ICN region code 53
- Claims will be automatically adjusted by HP and the necessary A/Rs, payouts and reimbursements will be generated

# Patient Liability

- **When a claim is recouped the system will take the patient liability by way of a recoupment**

- If the claim is resubmitted, the system will pay the claim and include the patient liability in the claim payment

- If the provider does not resubmit the claim and is seeking reimbursement for the patient liability by way of a payout, the DSS Convalescent Unit must be contacted.
  - Proof (general ledger, patient account ledger) must be provided illustrating that the money is owed to the provider, and not the client

# Claim Denials and Resolution

## EOB Code Description:

### 1024 Provider is not authorized to bill for this client

**Cause**
For Assisted Living, Acquired Brain Injury, Connecticut Home Care, Personal Care Assistance and Hospice claims, DSS has not yet updated EMS with authorization for the client to be serviced by the billing provider.

**Resolution**
The claim is not payable until EMS is updated with the client's authorization for the client to be serviced by the billing provider.

To determine if EMS has been updated, perform a client eligibility verification transaction. Once EMS has been updated, resubmit the claim.

# Claim Denials and Resolution

## EOB Code Description:

**0702 Hospice room and board not covered without nursing home authorization**

### Cause

The hospice claim was submitted with Revenue Center Code (RCC) 658 (Hospice Room and Board-Nursing Facility) for a client who has not received authorization by the Department of Social Services to be in the nursing home.

### Resolution

Once the nursing home authorization has been added to the client's eligibility file, the claim can be resubmitted.

# Claim Denials and Resolution

## EOB Code Description:

### 0710 Revenue not covered for client enrolled in Medicare hospice

**Cause**

The hospice claim was submitted for a client who has been authorized for Medicare hospice services and the claim contains a Revenue Center Code (RCC) other than 658.

**Resolution**

Only RCC 658 is valid when billing a hospice claim for a client with a Medicare hospice lock-in. Correct the RCC and resubmit the claim, otherwise, the claim is not payable.

# Claim Denials and Resolution

## EOB Code Description:

**0711 Claim denied. Client does not have hospice lock-in**

### Cause

The hospice claim is submitted for a client who has not yet been authorized by the Department of Social Services to receive hospice services from the billing provider.

Tip: DSS should execute the client's election into the hospice program within 10 business days from date of receipt of the election form. If the lock-in is not in place within 10 days of the submission of the election form to DSS, the hospice provider should contact DSS. DSS will not back date election forms not received within 10 days of election.

### Resolution

Perform a client eligibility verification transaction to determine if the client has been locked-in to the billing hospice agency.

If the lock-in is in place, resubmit the claim to HP.

If lock-in is not authorized for the date of service:

- If services billed are Revenue Center Code (RCC) 658 (Hospice Room and Board-Nursing Facility), the Nursing Home must bill these charges as a routine room and board claim.
- If services billed are either RCC 651 (Hospice/RTN Home) or 652 (Hospice/CTNS Home), the Hospice must bill comparable Home Health services under their Home Health Agency Provider Number.
- If services billed are RCC 656 (Hospice/IP Non-Respite), either the Hospital or Nursing Home must bill charges as a routine Hospital or Nursing Home stay.
- If services billed are RCC 657 (Hospice/Physician), the professional provider must bill charges as a routine medical claim.

# Hospice Reminders

## Primary Diagnosis Changes

- Effective January 1, 2015 and forward, the following **diagnosis codes**, based on ICD-9-CM coding guidelines, **should not be used** as the **primary diagnosis** when submitting Hospice Services:
  - 799.3 (Debility, unspecified )
  - 780.7 (Malaise and Fatigue)
  - 780.79 (Other malaise and fatigue)
  - 783.7 (Adult failure to thrive)
  - 294.10 (Dementia in diseases classified elsewhere without behavioral disturbance)
  - 294.11 (Dementia in diseases classified elsewhere with behavioral disturbance)
- When dementia diagnosis codes are present, the **underlying condition** should be coded as the **primary diagnosis**
- The **dementia condition** could be coded as the **secondary diagnosis**

**NOTE: Claims submitted** with any of the **aforementioned diagnosis codes** as the **primary diagnosis will be denied**

# Hospice Reminders

## Notice of Hospice Election Submission Guidelines

- **Exceptions to untimely submission of the NOE:**

- Fire, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate
- An event that produces a data filing problem due to a Department systems issue that is beyond the control of the hospice
- Retroactive client eligibility
- Other circumstances determined by the Department to be beyond the hospice's control

***NOTE: The Hospice provider must call the HP Provider Assistance Center at 1-800-842-8440 if one of the above qualifying circumstances prevents you from submitting your NOE within the timely filing requirements***

***Reference provider bulletin: PB14 - 80 for additional information***

# ICD-10

## ICD-10 Readiness

- ✓ On October 1, 2015, the ICD-9 code set to report medical diagnosis and inpatient procedures will be replaced by ICD-10 code sets

Important claim impacts include:

- ✓ **Hospice claims** must be billed with all codes from the same code set (ICD-9 or ICD-10) based on the date of service
- ✓ **Global 837 transactions** require ICD-10 Code Set be submitted with the appropriate Code Qualifiers
- ✓ **Web claims transmitted on the ctdssmap.com Web site** changes require providers to select the Code Set for Diagnosis tab and select either ICD- 9 or ICD-10 Code Set from a drop down list
- ✓ Providers will also have to select the Code Set on the Cause of Injury and Reason for Visit diagnosis tabs
- ✓ **UB-04 Paper Claim**
  - Current version of the claim form will continue to be used
  - Field 66 DX – Provider must enter the applicable ICD indicator to identify which version of the ICD codes is being reported

***Reference provider bulletin: PB14-20 & PB15-61 for additional information***

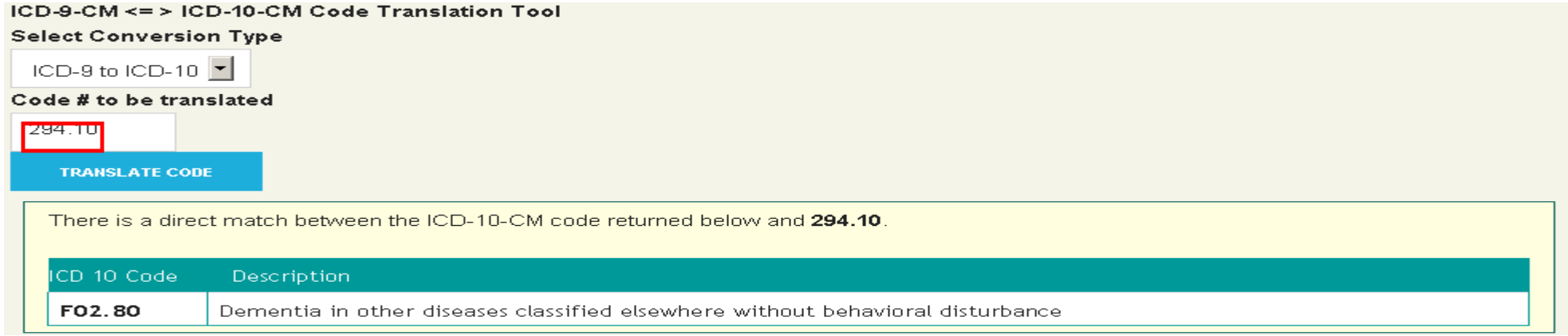
# ICD-10

## ICD-10 Readiness

### ICD-10 Related EOB Codes for all Claim Types:

- ✓ 492 - ICD-9 diagnosis code qualifiers after ICD-10 implementation date
- ✓ 485 - Diagnosis codes must be all same code set
- ✓ 4027 - Diagnosis not covered for date of service
- ✓ 4039 - The primary diagnosis code is not covered
  - A list of applicable ICD-10 related EOB codes will be maintained in the ICD-10 Important Message posted on the www.ctdssmap.com Home page
  - ICD-9 conversion to ICD-10 is available at: http://icd10cmcode.com/icd9to10conversion.php

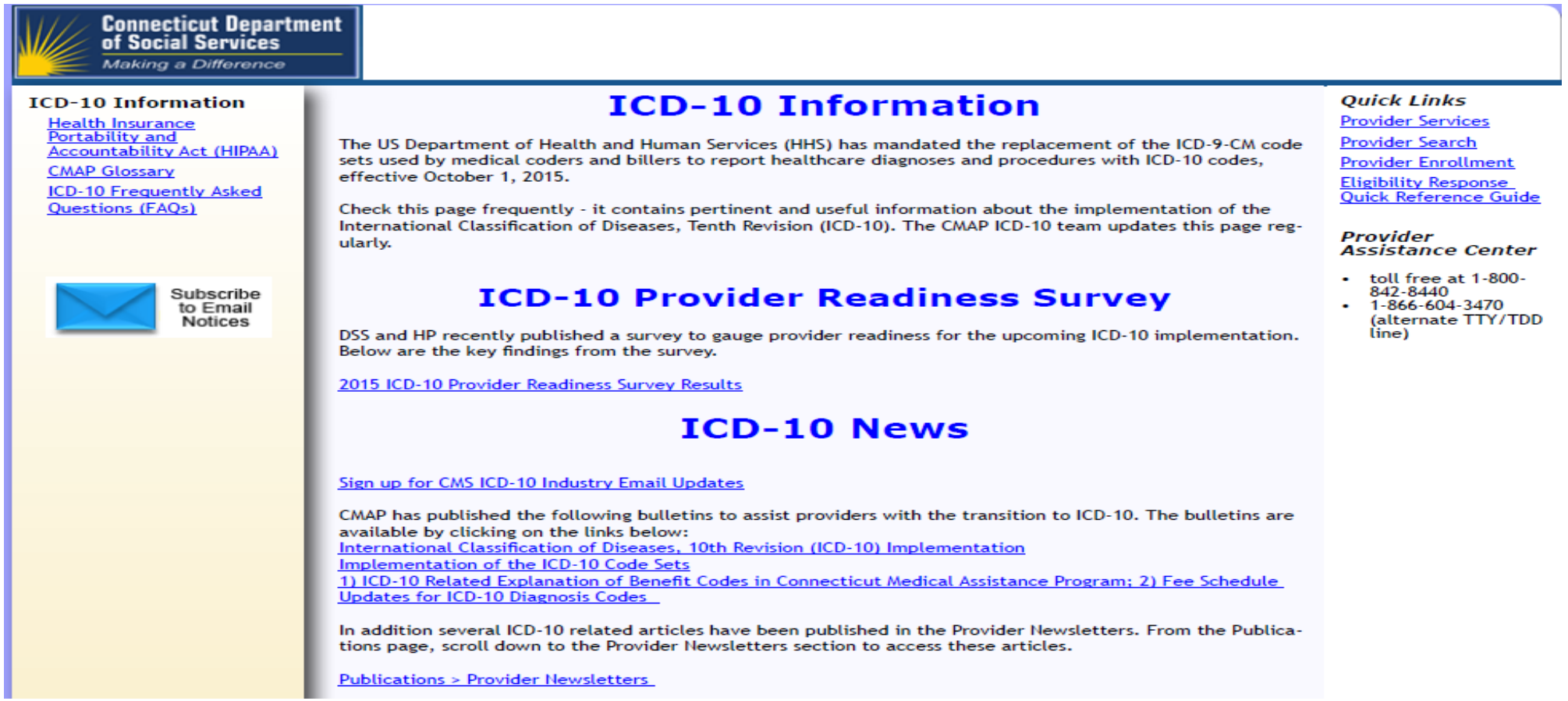
*Example:*




*Reference provider bulletins: PB14-20 & PB15-47 for additional information*

# ICD-10 Readiness

## ICD-10 Implementation Important Message



Connecticut Department of Social Services
Making a Difference

**ICD-10 Information**

- Health Insurance Portability and Accountability Act (HIPAA)
- CMAP Glossary
- ICD-10 Frequently Asked Questions (FAQs)

Subscribe to Email Notices

# ICD-10 Information

The US Department of Health and Human Services (HHS) has mandated the replacement of the ICD-9-CM code sets used by medical coders and billers to report healthcare diagnoses and procedures with ICD-10 codes, effective October 1, 2015.

Check this page frequently - it contains pertinent and useful information about the implementation of the International Classification of Diseases, Tenth Revision (ICD-10). The CMAP ICD-10 team updates this page regularly.

## ICD-10 Provider Readiness Survey

DSS and HP recently published a survey to gauge provider readiness for the upcoming ICD-10 implementation. Below are the key findings from the survey.

2015 ICD-10 Provider Readiness Survey Results

## ICD-10 News

Sign up for CMS ICD-10 Industry Email Updates

CMAP has published the following bulletins to assist providers with the transition to ICD-10. The bulletins are available by clicking on the links below:
International Classification of Diseases, 10th Revision (ICD-10) Implementation
Implementation of the ICD-10 Code Sets
1) ICD-10 Related Explanation of Benefit Codes in Connecticut Medical Assistance Program; 2) Fee Schedule Updates for ICD-10 Diagnosis Codes

In addition several ICD-10 related articles have been published in the Provider Newsletters. From the Publications page, scroll down to the Provider Newsletters section to access these articles.

Publications > Provider Newsletters

***Quick Links***

- Provider Services
- Provider Search
- Provider Enrollment
- Eligibility Response Quick Reference Guide

***Provider Assistance Center***

- toll free at 1-800-842-8440
- 1-866-604-3470 (alternate TTY/TDD line)

# ICD-10 Readiness

## ICD-10 Implementation Resources

### General Resources

AAPC ICD-10 Code Translator. This tool is based on the General Equivalency Mapping (GEM) files published by CMS and is intended to assist providers in code selection. Some clinical analysis may be required to choose the most accurate code.

International Classification of Diseases (ICD). The World Health Organization (WHO) link provides you with other links and downloads to help you better understand ICD coding and the transition from ICD-9 to ICD-10.

Centers for Disease Control and Prevention (CDC). This link is to the ICD-10 page of the CDC. Additional links take you to ICD-10-related documents, web pages, and other sources.

National Uniform Claim Committee (NUCC). The NUCC is an authoritative voice regarding national standard data content and data definitions for professional (non institutional) healthcare claims and related encounter data in the United States.

### ICD-10 Mailbox

If you have questions about ICD-10 that you would like the ICD-10 team to address, please submit them to: cmapicd10questions@hp.com

# ICD-10 Readiness

## ICD-10 Implementation Resources

### ICD-10 Questions Mailbox

If you have questions about ICD-10 that you would like the ICD-10 team to address, please submit your questions to cmapicd10questions@hp.com.

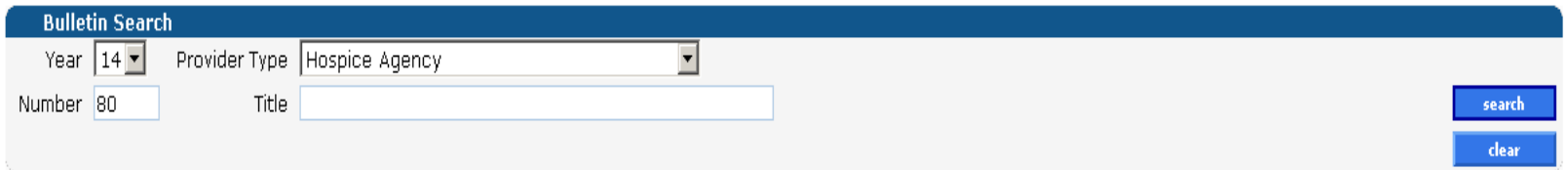
### ICD-10 Testing

If you would like to become a beta tester, please contact the CMAP testing team at CTICD10testing@hp.com and include:

- your Trading Partner ID
- NPI and AVRS ID for the claims you will be testing
- your contact name and phone number
- email address you wish the PDF Remittance Advice to be emailed to
- type of claims you will be testing
- please include "ICD10 Testing" in the subject of the email

# Resources

- **Connecticut Medical Assistance Program Web site – [www.ctdssmap.com](http://www.ctdssmap.com)**




## Information > Publications **> Provider Manuals**

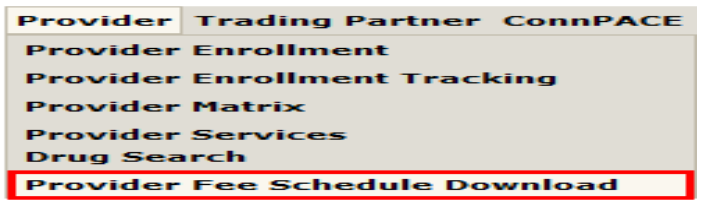
**Provider Manuals**

| Chapter | Title |
|---|---|
| 1 | Introduction |
| 2 | Provider Participation Policy |
| 3 | Provider Enrollment and Re-enrollment |
| 4 | Client Eligibility |
| 5 | Claim Submission Information<br>**Additional Chapter 5 Information**<br>• Carrier Listing Sorted by Name<br>• Carrier Listing Sorted by Code |
| 6 | Electronic Data Interchange Options |
| 7 | Specific Policy/Regulation<br>Hospice<br>View Chapter 7 |
| 8 | Provider Specific Claims Submission Instructions<br>Hospice<br>View Chapter 8 |
| 9 | Prior Authorization |
| 10 | Web/AVRS |
| 11 | Other Insurance and Medicare Billing Guides<br>Select a claim type<br>View Chapter 11 |
| 12 | Claim Resolution Guide |

# Resources

## CMAP Fee Schedules are available for download from the Web site

Select Provider Fee Schedule Download from the Provider drop-down menu




## You must read and accept the End User License Agreement

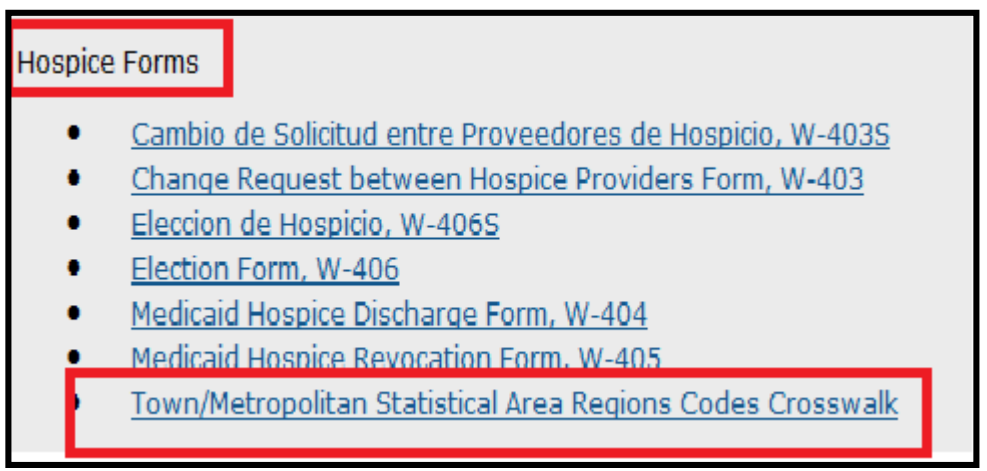

## click I Accept


Provider Fee Schedules are listed by provider type and specialty

Hold down the **control key** and **click**the **Hospice CSV link** to download the fee schedule

# Resources

The **fee schedule provides the rate by region.** The Hospice provider must **refer to the crosswalk located at publications>Forms>Hospice Forms** to determine the regional rate associated to the client's county and town of residence on file at the time of claim submission




| Town Code | Town Description | County Code | REGIONAL AREA or Metropolitan Statistical Area |
|---|---|---|---|
| 1 | Andover | 07 | 02 |
| 2 | Ansonia | 05 | 03 |
| 3 | Ashford | 08 | 05 |
| 4 | Avon | 02 | 02 |
| 5 | Barkhamsted | 03 | 05 |
| 6 | Beacon Falls | 05 | 03 |
| 7 | Berlin | 02 | 02 |
| 8 | Bethany | 05 | 03 |
| 9 | Bethel | 01 | 01 |
| 10 | Bethlehem | 03 | 05 |
| 11 | Bloomfield | 02 | 02 |
| 12 | Bolton | 07 | 02 |
| 13 | Bozrah | 06 | 04 |
| 14 | Branford | 05 | 03 |
| 15 | Bridgeport | 01 | 01 |
| 16 | Bridgewater | 03 | 05 |
| 17 | Bristol | 02 | 02 |
| 18 | Brookfield | 01 | 01 |
| 19 | Brooklyn | 08 | 05 |
| 20 | Burlington | 02 | 02 |
| 21 | Canaan | 03 | 05 |
| 22 | Canterbury | 08 | 05 |
| 23 | Canton | 02 | 02 |
| 24 | Chaplin | 08 | 05 |
| 25 | Cheshire | 05 | 03 |
| 26 | Chester | 04 | 02 |
| 27 | Clinton | 04 | 02 |
| 28 | Colchester | 06 | 04 |
| 29 | Colebrook | 03 | 05 |
| 30 | Columbia | 07 | 02 |
| 31 | Cornwall | 03 | 05 |
| 32 | Coventry | 07 | 02 |
| 33 | Cromwell | 04 | 02 |
| 34 | Danbury | 01 | 01 |
| 35 | Darien | 01 | 01 |
| 36 | Deep River | 04 | 02 |
| 37 | Derby | 05 | 03 |
| 38 | Durham | 04 | 02 |
| 39 | Eastford | 08 | 05 |
| 40 | East Granby | 02 | 02 |
| 41 | East Haddam | 04 | 02 |
| 42 | East Hampton | 04 | 02 |
| 43 | East Hartford | 02 | 02 |
| 44 | East Haven | 05 | 03 |
| 45 | East Lyme | 05 | 03 |

# Resources

## Home > **Important Messages**

**Important Messages**

Attention 340B Hospital Providers: National Drug Code (NDC) Related Claim Denials (Posted 6/12/15)

Attention Providers: Drug Utilization Review (DUR) Newsletter Notification (Posted 6/12/15)

Hospital interChange Issues (Updated 6/10/15)

## Information > Publications > **Provider Newsletters**

- Quarterly publications to providers on a wide range of topics

**Provider Newsletters**

- June 2015 interChange Newsletter
- March 2015 interChange Newsletter
- December 2014 interChange Newsletter
- October 2014 interChange Newsletter
- Provider Newsletter Archives
- EHR Newsletter: Hospitals May 2011

## Information > Publications > **Claims Processing Information**

- Guides and FAQs to assist with billing/claims processing

**Claims Processing Information**

- Eligibility Response Quick Reference Guide
- Internet Claims Submission FAQ
- Dental Other Insurance Billing Guide
- Institutional Other Insurance/Medicare Billing Guide
- Professional OI/Medicare Billing Guide

# Contacts

- ***HP Provider Assistance Center (PAC)***
  - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
  - CTDSSMAP-ProviderEmail@hp.com

- ***HP Electronic Data Interchange (EDI) Help Desk***
  - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

- ***CHNCT Provider Relations*** *(prior authorizations)*
  - 1-800-440-5071 – Monday through Friday, 9 a.m. to 7 p.m. (EST)
- ***www.huskyhealth.com***

- ***www.CTDSSMAP.com***

# *Time for Questions*

# Thank You For Attending the Connecticut Medical Assistance Program Hospice Refresher Training

# Please complete the workshop evaluation, your comments are appreciated!