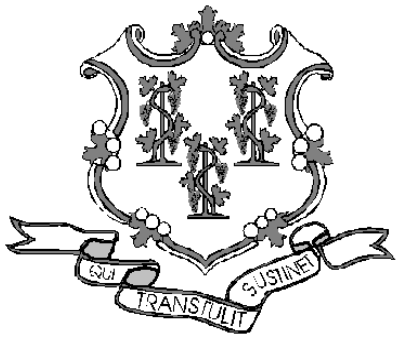
Connecticut Department of Social Services

Caring for Connecticut



Hospital Billing Changes Workshop

Presented by

The Department of Social Services

& HP Enterprise Services

Training Topics

- **Provider Bulletins**
- **Hospital Billing Changes**
- **RCC 310-319**
- **OPR Requirements and Edits**
- **Enrolling OPR Providers**
- **Account Demographics**
- **ICD-10**
- **Questions**

Provider Bulletins

Provider Bulletins

- Access the Publications page by selecting Publications from either the Information box on the left hand side of the home page (www.ctdssmap.com) or from the Information drop-down menu.

- Bulletin Search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type.
  - When searching by provider title, you can search by any word as long as that word is in the title of the bulletin.

Provider Bulletins

Provider Bulletins

Home | Information | Provider | Trading Partner | ConnPACE | Pharmacy Information

home | publications | links | hipaa

Information

Bulletin Search

Year 13 ▾ Provider Type Hospital ▾

Number Title

search

clear

Search Results

Bulletin Number	Title	Published Date
PB13-44	Claims for Outpatient Surgery and Pathology Lab Services	08/16/2013
PB13-43	New Requirement for Prior Authorization of Incisional and Ventral Hernia Repairs	08/19/2013
PB13-41	Clarification of New Diagnosis Requirement for Prevacid Solutab Coverage for Cl...	07/22/2013
PB13-41	Change to Diagnosis Requirements for Medicare Part B Cost Avoidance Associated ...	07/22/2013
PB13-36	Overpayments for Clinical Laboratory Services	06/26/2013
PB13-33	July 1, 2013 Changes to the Connecticut Medicaid Preferred Drug List (PDL)	06/18/2013
PB13-33	Reminder About the 5 day Emergency Supply	06/18/2013
PB13-33	Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL...	06/18/2013
PB13-29	NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SPEND DOWN POLICY CLARIFICATION	05/29/2013
PB13-28	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/16/2013
PB13-26	New Prior Authorization Criteria for Proton Pump Inhibitors (PPIs)	05/20/2013
PB13-24	Implementation of Affordable Care Act Claim Edits	05/13/2013
PB13-21	Children's Behavioral Health Rehabilitation Billing Procedures	04/22/2013
PB13-15	Transition to the Updated ADA 2012 J434 Dental Claim Form	03/27/2013
PB13-11	RCC Crosswalk to New Psychiatric Procedure Codes for 2013	03/13/2013
PB13-04	Elimination of Paper Re-enrollment Applications	01/27/2013
PB13-03	Electronic Funds Transfer Change Notification	02/03/2013

Provider Bulletins

Provider Bulletin 2013-44 “Claims for Outpatient Surgery and Pathology Lab Services”

- The purpose of this bulletin is to notify outpatient hospitals that effective November 1, 2013, the Department of Social Services (DSS) will require hospitals to bill all laboratory services, including Revenue Center Codes (RCC) 310-319 (laboratory-pathology) to bill with a appropriate CPT code.

- The bulletin also provides a link to access the lab fee schedule.

Hospital Billing Changes

Revenue Center Codes 310-319

- Outpatient hospitals will be required to bill for RCCs 310-319 with a CPT code in the same manner hospitals currently bill for RCCs 300-309.

- Hospitals should no longer lump those services under one detail line and will be required to list all services separately with the appropriate CPT code.

- RCC billed without a CPT code will deny with Explanation of Benefits (EOB) 391 “Revenue Center Code Requires a HCPCS/Procedure Code.”

Hospital Billing Changes

Revenue Center Codes 310-319

- Effective November 1, 2013, payment for tests billed under RCCs 310-319 will be either paid at the fee listed on the consolidated lab fee schedule or remain as a cost to charge ration.

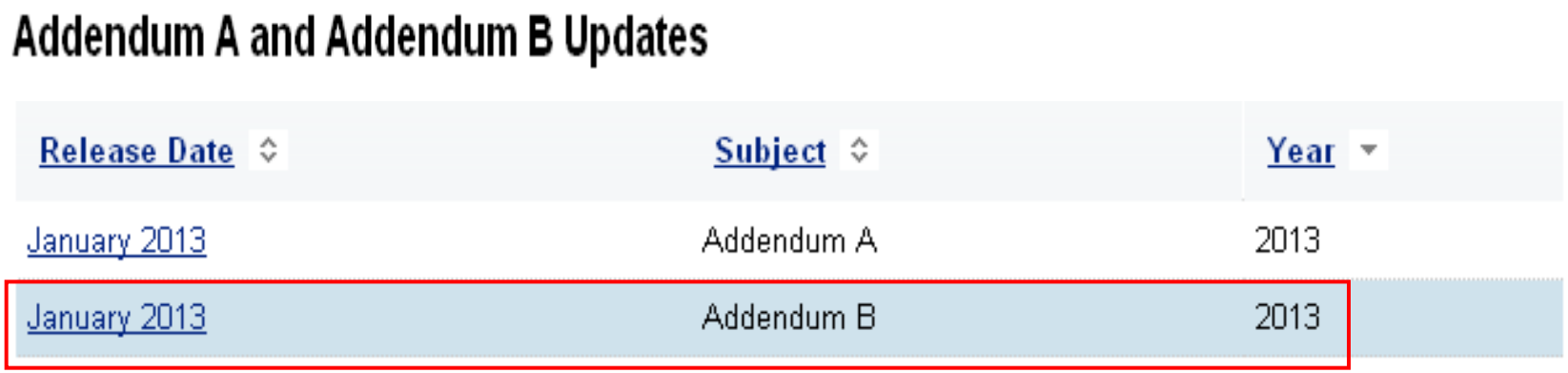
- Please refer to the following link to determine if the RCC + CPT combination will be paid off the Department's consolidated fee schedule or as a ratio of costs to charges.

  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

Hospital Billing Changes

Revenue Center Codes 310-319

- Once on the CMS Web site page, click on “January 2013 Addendum B.”



- Then click on “Addendum B” and finally “January 2013 Web Addendum.”

Hospital Billing Changes

Revenue Center Codes 310-319

- Click on Accept on the agreement page and select the excel spreadsheet titled “January 2013 Web Addendum B01.01.13.”

A	B	C	D
	Addendum B.-Final OPPS Payment by HCPCS Code for CY 2013		
	CPT codes and descriptions only are copyright 2011 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2011/12 American Dental Association. All Rights Reserved.		
HCPCS Code	**Short Descriptor**	**SI**	**APC**
88040	Forensic autopsy (necropsy)	E	
88045	Coroners autopsy (necropsy)	E	
88099	Necropsy (autopsy) procedure	E	
88104	Cytopath fl nongyn smears	X	0433
88106	Cytopath fl nongyn filter	X	0433
88108	Cytopath concentrate tech	X	0433
88112	Cytopath cell enhance tech	X	0433
88120	Cytp urne 3-5 probes ea spec	X	0661
88121	Cytp urine 3-5 probes cmptr	X	0661
88125	Forensic cytopathology	X	0433
88130	Sex chromatin identification	A	
88140	Sex chromatin identification	A	
88141	Cytopath c/v interpret	N	
88142	Cytopath c/v thin layer	A	
88143	Cytopath c/v thin layer redo	A	
88147	Cytopath c/v automated	A	
88148	Cytopath c/v auto rescreen	A	
88150	Cytopath c/v manual	A	
88152	Cytopath c/v auto redo	A	
88153	Cytopath c/v redo	A	
88154	Cytopath c/v select	A	
88155	Cytopath c/v index add-on	A	

Hospital Billing Changes

Revenue Center Codes 310-319

- If the status indicator (SI) is “X” the RCC + CPT combination will pay as a ratio of cost to charge based on the hospital’s fee schedule for RCC 310-319 per DSS rate agreement letter.

- If the status indicator is any value other then “X”, such as “A”, “N” or “E” the claim will pay based on the Consolidated Lab Fee Schedule.
  - The Laboratory Fee Schedule can be accessed and downloaded by going to www.ctdssmap.com, then go to “Provider”, then to “Provider Fee Schedule Download”, then to the “Lab” fee schedule. To access the CSV file press the control key while clicking the CSV link, then select “Open”.

Hospital Billing Changes

Revenue Center Codes 310-319

- If the lab service is not on the Consolidated Lab Fee Schedule the service will be denied with EOB 4831 “Service is Not Payable on Date of Service.” Example: Procedure code 88105.

	Lab							
Procedure	Proc description	Mod1	Mod1 des	Rate Type	Max Fee	Effective Date	End Date	PA
36415	COLLECTION OF V			DEF	2.85	7/1/2006	12/31/2012	
36415	COLLECTION OF V			DEF	2.71	1/1/2013	12/31/2299	
88104	CYTOPATH FL NOI			DEF	24.45	7/1/2006	12/31/2012	
88104	CYTOPATH FL NOI			DEF	23.23	1/1/2013	12/31/2299	
88104	CYTOPATH FL NOI	26		DEF	12.23	8/18/2010	12/31/2012	
88104	CYTOPATH FL NOI	26		DEF	11.62	1/1/2013	12/31/2299	
88104	CYTOPATH FL NOI	TC		DEF	12.23	8/18/2010	12/31/2012	
88104	CYTOPATH FL NOI	TC		DEF	11.62	1/1/2013	12/31/2299	
88106	CYTOPATH FL NOI			DEF	27.8	7/1/2006	12/31/2012	
88106	CYTOPATH FL NOI			DEF	26.41	1/1/2013	12/31/2299	
88106	CYTOPATH FL NOI	26		DEF	13.9	8/18/2010	12/31/2012	
88106	CYTOPATH FL NOI	26		DEF	13.21	1/1/2013	12/31/2299	
88106	CYTOPATH FL NOI	TC		DEF	13.9	8/18/2010	12/31/2012	
88106	CYTOPATH FL NOI	TC		DEF	13.21	1/1/2013	12/31/2299	

Ordering, Prescribing, Referring (OPR) Requirements and Edits

- Sections 6401 and 6501 of the Affordable Care Act (ACA) mandate that ordering and referring providers who render services to HUSKY clients be enrolled in the Connecticut Medical Assistance Program (CMAP). To support this mandate, beginning with claim dates of service May 1, 2013, DSS implemented new claim edits to validate that attending, referring, and rendering providers submitted on Institutional claims are enrolled in the CMAP.

  - EOB 1033 “Informational Only - Attending physician not enrolled on date of service.”
  - EOB 1034 “Informational Only - Rendering provider not enrolled on date of service.”

OPR Requirements and Edits

- These edits was originally implemented in a post and pay status which means if the provider is not enrolled, the edit will be displayed on the claim, but the claim will not be denied for that reason. This post and pay period will allow DSS to assess the impact of setting these edits to deny and enable billing providers to identify those providers who still need to enroll in CMAP.

Explanation of Benefit Code	Claim Type	Paper claim location	Web claim location	PES claim location	ASC X12 837 Loop	ID Qual
1033 Informational Only - Attending physician not enrolled on date of service	Institutional	Field 76	Institutional claim panel	Header 2	Header: 2310A	71
1034 Informational Only - Rendering provider not enrolled on date of service	Institutional	Fields 78 or 79	Institutional claim panel	Field not present	Header: 2310D Detail: 2420C	82

OPR Requirements and Edits

- EOB 1033 “Attending Physician not Enrolled on Date of Service” will begin to deny on outpatient claims, including Medicare crossover claims, starting with dates of service on or after **(TBD)** if the referring provider is not on the submitted claim, and the claim contains a RCC in Attachment A* and the attending provider is not enrolled in CMAP.
  - * Attachment A RCC list can be found under provider bulletin **2013-XX “**The Implementation of the Ordering, Prescribing, and Referring (OPR) Claim Edits” or under the Web site www.ctdssmap.com, under Information, Publications then Provider Manual Chapter 8 – Hospitals.

- EOB 1034 “Informational Only - Rendering provider not enrolled on date of service” will be inactivated and it will no longer appear on hospital claims.

OPR Requirements and Edits

- The following edit will begin to deny claims beginning with dates of service November 1, 2013 and forward on Inpatient and Outpatient claims.
  - EOB 1035 "Referring physician not enrolled on date of service."

Explanation of Benefit Code	Claim Type	Paper claim location	Web claim location	PES claim location	ASC X12 837 Loop	ID Qual
1035 Informational Only - Referring provider not enrolled on date of service	Institutional	Fields 78 or 79	Institutional claim panel	Field not present	Header: 2310F Detail: 2420D	DN

OPR Requirements and Edits

- For inpatient and outpatient claims only, if the referring provider NPI is entered on the claim and they are not enrolled it will deny with EOB 1035 “Referring Provider Not Enrolled on Date of Service” effective with dates of service on or after 11/1/2013.

- For Medicare Crossover Claims begin to deny claims with dates of service on or after 12/1/2013.

- Referring provider is only required when different than the attending provider. This edit will only set if there is a provider number in the referring field and the provider is not enrolled on the date of service.

OPR Requirements and Edits

- The NPI of the attending physician supervising the care of the patient should be submitted on the claim if the ordering or referring provider is an unlicensed resident, as unlicensed residents are not permitted to enroll in CMAP.

- The supervising attending physician is the physician who is supervising the resident who is providing the *immediate* care of that particular patient.

OPR Enrollment

Provider Enrollment Clarification

- Providers employed or contracted by the hospital must be enrolled in CMAP.

- To determine whether a provider is enrolled, refer to the following link on the Husky Health Web site: http://www.huskyhealthct.org/provider_lookup.html.

- To determine whether a behavioral health provider is enrolled, contact Value Options @ 1-877-55-CTBHP or 1-877-552-8247

- To determine whether a dental provider is enrolled, contact the Connecticut Dental Health Partnership at 1-855-CT-Dental or 1-855-283-3682

OPR Enrollment

Provider Enrollment Clarification

- When enrolling these providers the hospital/provider must select the enrollment option of Employed/Contracted by an Organization and **not** the Ordering, Prescribing, Referring provider only option.

- The Ordering, Prescribing, Referring enrollment option is strictly for those providers who are not affiliated with an organization.

OPR Enrollment

Provider Enrollment Clarification

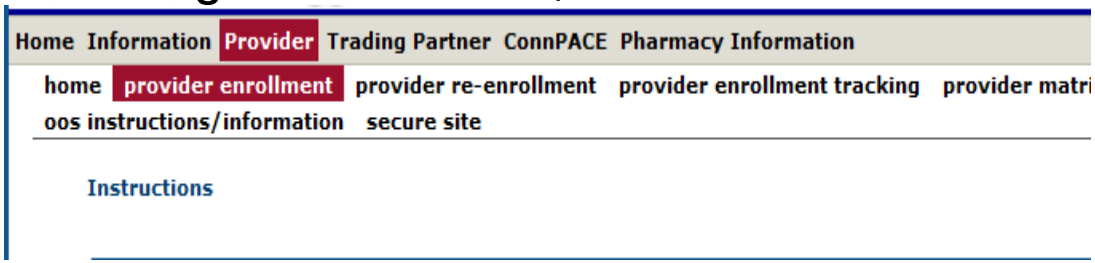
- The following is a list of required provider types for hospital based providers that must be enrolled.

Practitioner	Provider Type
Physician	31
Advanced Practice Registered Nurse (APRN)	09
Psychologist	33
Physician Assistant (PA)	97
Certified Nurse Midwife (CNM)	32
Dentist, with the exception of hygienists	27
Chiropractor	15
Podiatrist	14
Audiologist	17

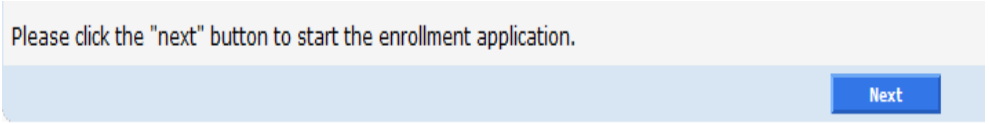
OPR Enrollment

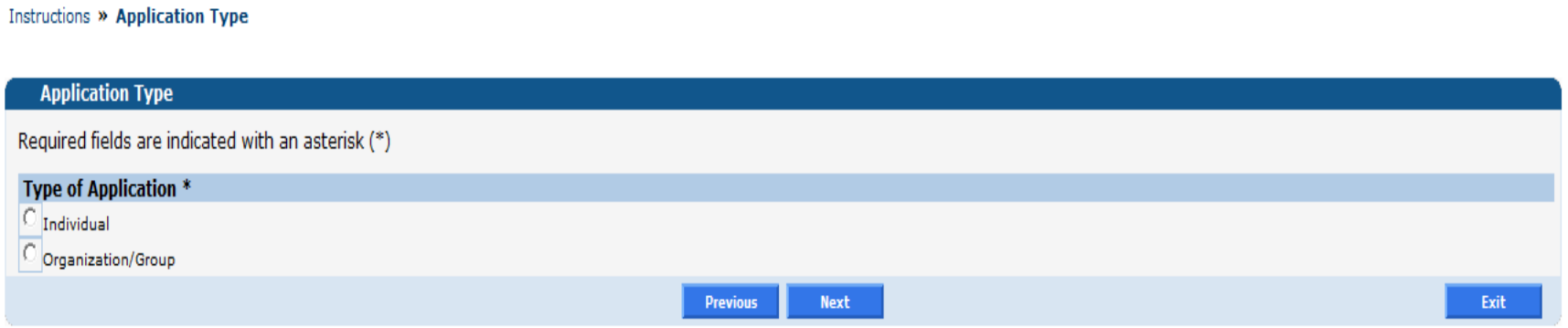
Provider Enrollment Clarification

- The provider enrollment wizard is available via the Web site by clicking on Provider, then Provider Enrollment.



- Then by clicking next and selecting individual provider you will see enrollment options.

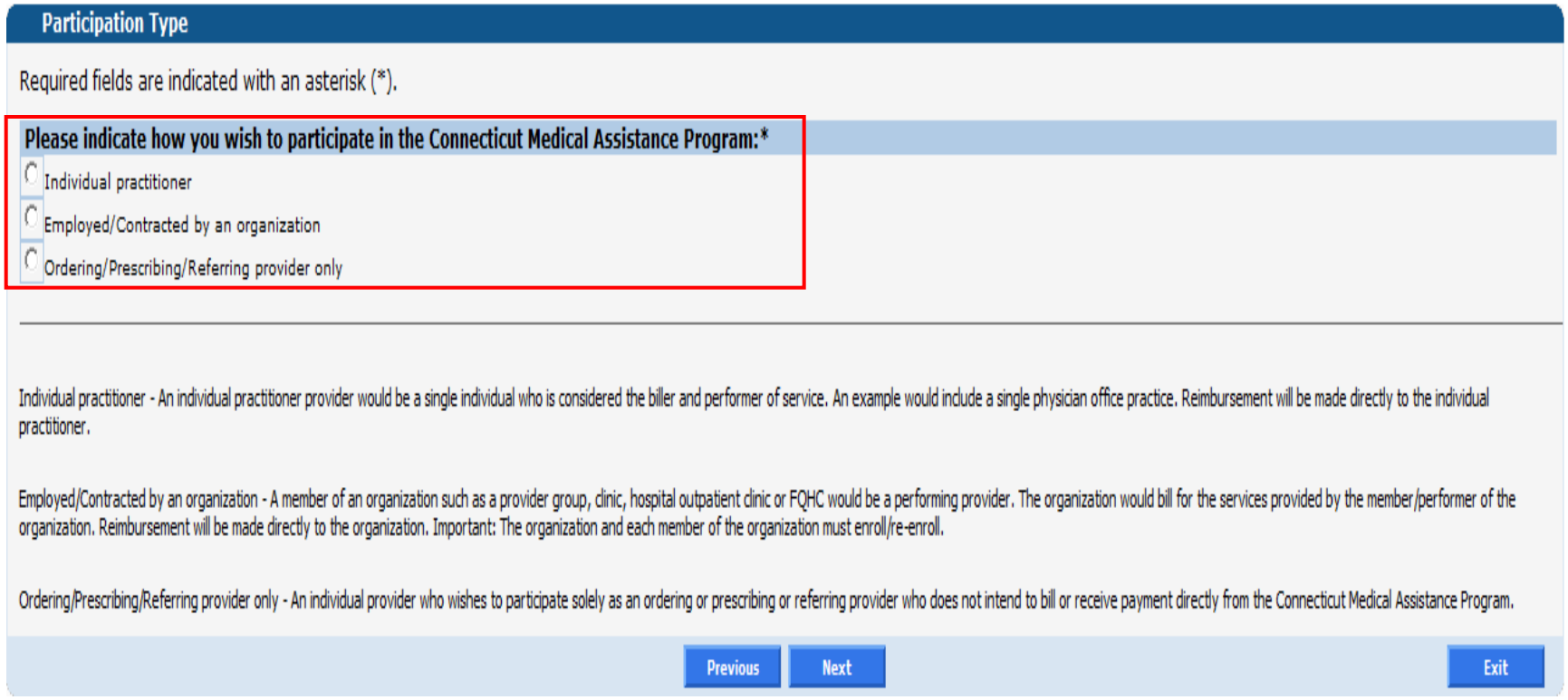




OPR Enrollment

Provider Enrollment Options:

- Employed/Contracted by an organization.
- Ordering/Prescribing/Referring provider only.



Account Demographics

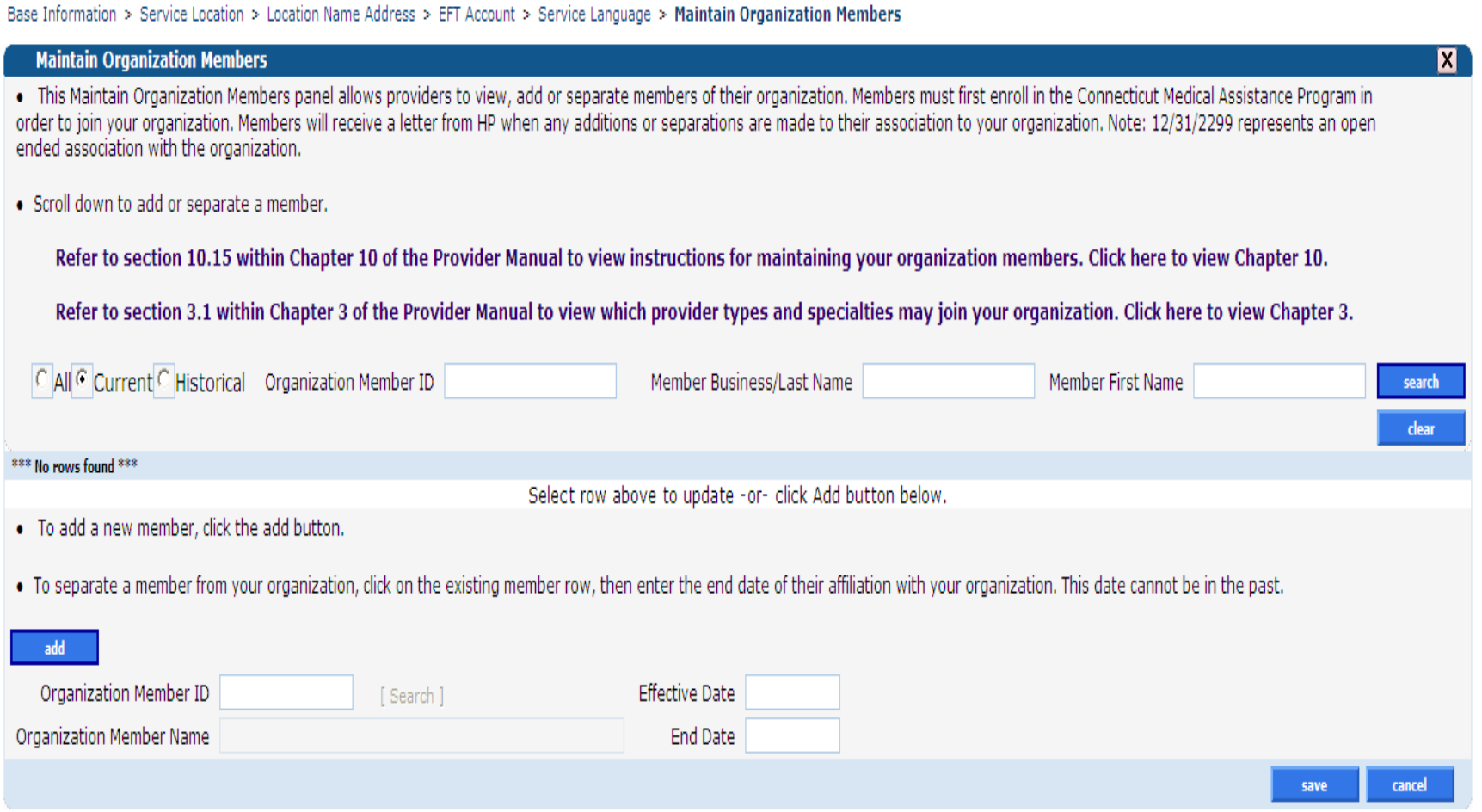
Maintain Organization Members

- As of January 1, 2012 DSS required most performing providers employed by or contracted with hospitals or clinics to enroll in the Connecticut Medical Assistance Program.

- Maintain Organization Members panel allows providers to add, view, or separate members of their hospital. Members must first be enrolled in the Connecticut Medical Assistance Program in order to join your organization.
  - Hospitals can only tie providers to their outpatient hospital AVRS ID.
- Members will receive a letter from HP when any additions or separations are made to their association by your organization.

Account Demographics

Maintain Organization Members



Account Demographics

Maintain Organization Members

- To add a new member (a provider must be already enrolled in Medicaid), click the add button.

- Search for the provider

  - Enter provider's NPI or AVRS ID and hit search.

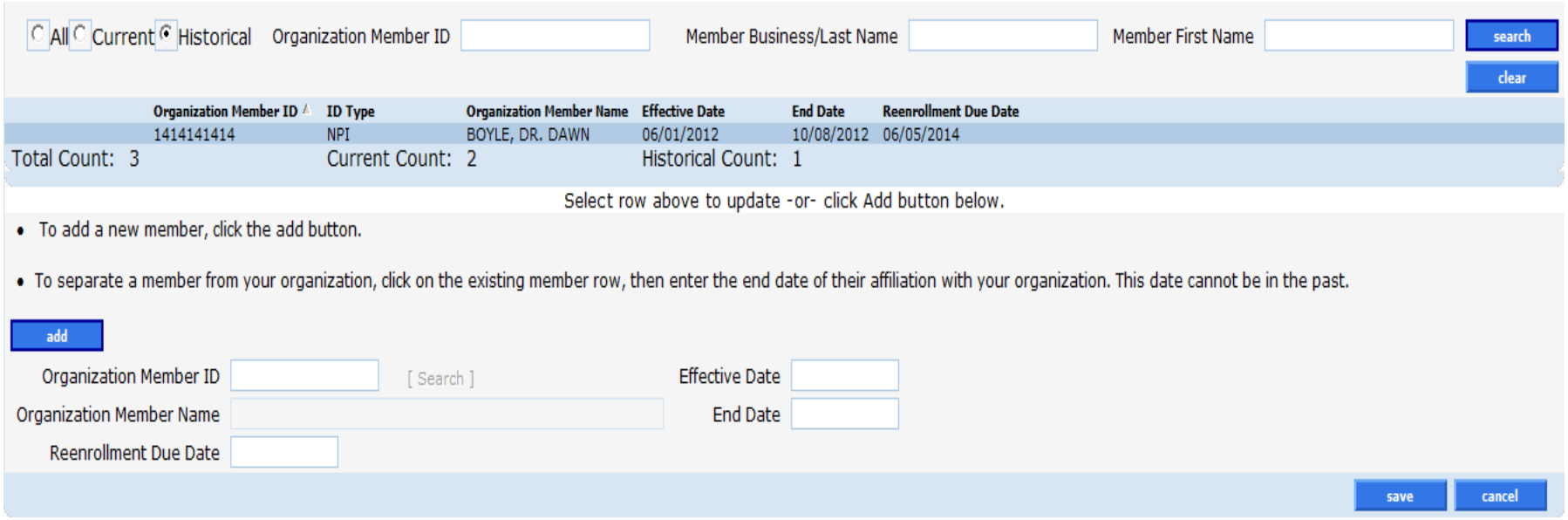
- Enter effective date (date of hire or start date at the hospital). This can be backdated up to 6 months from today's date. If it needs to be backdated longer then 6 months it will need DSS approval.

- Enter end date as 12/31/2299 and hit save.

Account Demographics

Maintain Organization Members

- The re-enrollment due date for your members will appear under maintaining organization.
- Hospitals should tie providers to their organization only when they are contracted with the hospital.



Hospital Billing

ICD-10 Changes

- On October 1, 2014 the ICD-9 code set used to report medical diagnosis and inpatient procedures will be replaced by ICD-10 code sets.

- The transition to ICD-10 is required for all providers, payers and vendors.

- Please note this change does not affect CPT coding for outpatient procedures and physician services.

- The American Medical Association (AMA) ICD-10-CM code set book is available for purchase on the Web. There are multiple Web sites selling the ICD-10-CM code set book.

Hospital Billing Changes

ICD-9 Surgical Codes

- Due to the HIPAA 5010 implementation, when submitting outpatient surgical claims you are no longer required to submit ICD-9 surgical procedure codes.

- Starting October 1, 2013, you will no longer be able to enter ICD-9 surgical procedure code when submitting outpatient or outpatient crossover claims through Web claim submission.

- ICD-9 surgical codes can still be submitted on inpatient and inpatient crossover claims.

Training Session Wrap Up

- Where to go for more information www.ctdssmap.com
  - Important Messages
    - Hospital interChange IM updated monthly
  - Provider Bulletins
- HP Provider Assistance Center (PAC): Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays:
  - 1-800-842-8440
  - 1-800-688-0503 (EDI Help Desk)

Time for Questions

- Questions & Answers