Connecticut Department of Social Services

Caring for Connecticut

Hospital Refresher Workshop

Presented by

The Department of Social Services

& HP Enterprise Services

Training Topics

- **Provider Bulletins**
- **Outpatient Claim Billing Changes**
- **Explanation of Benefit Codes**
- **Web Claim Submission (Medicare Primary)**
- **Enrollment of Residents**
- **Hospital Modernization Web Page**
- **Provider Drug Search**
- **ICD-10**
- **Questions**

Provider Bulletins

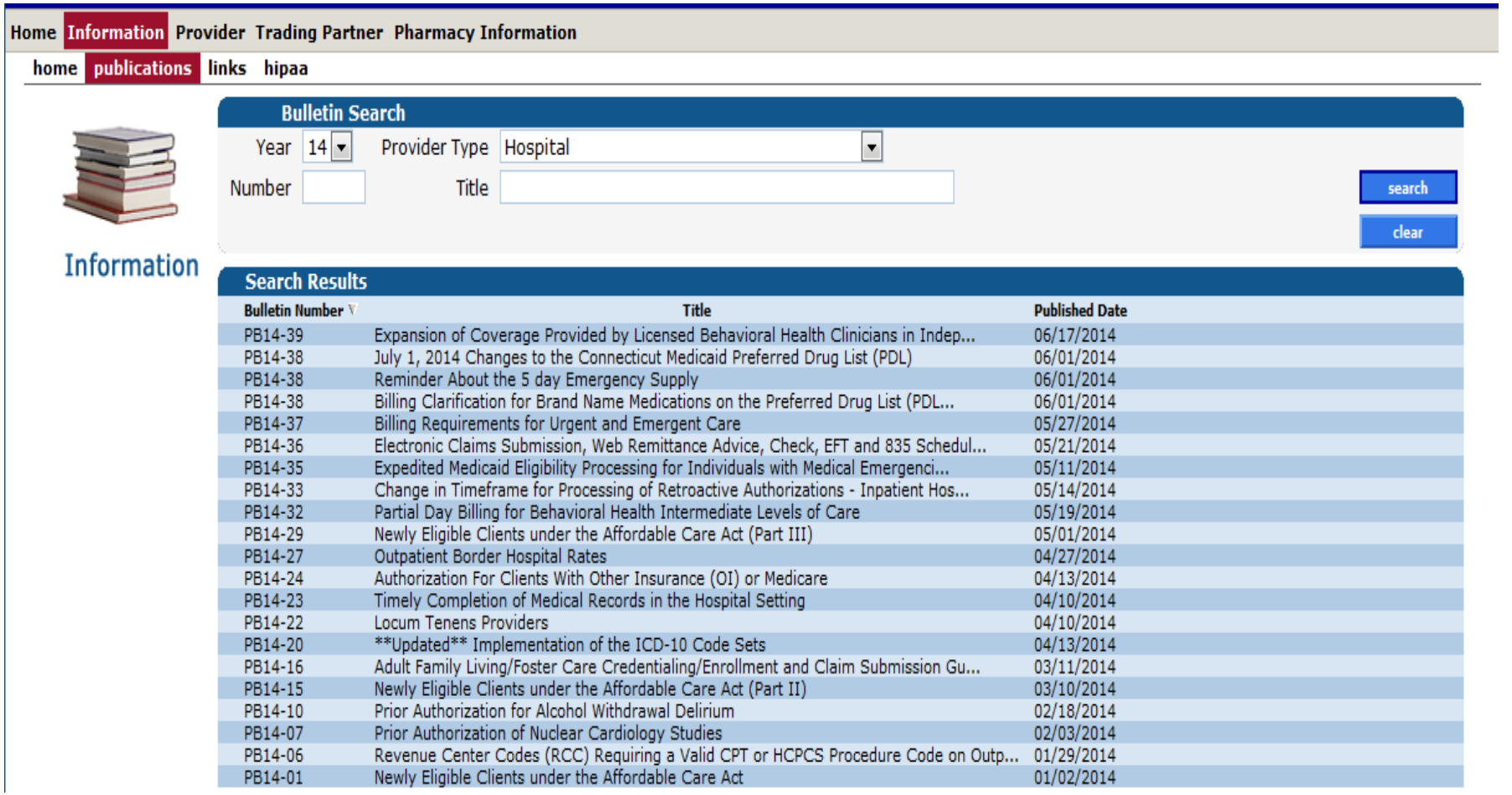
Provider Bulletins

- 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.

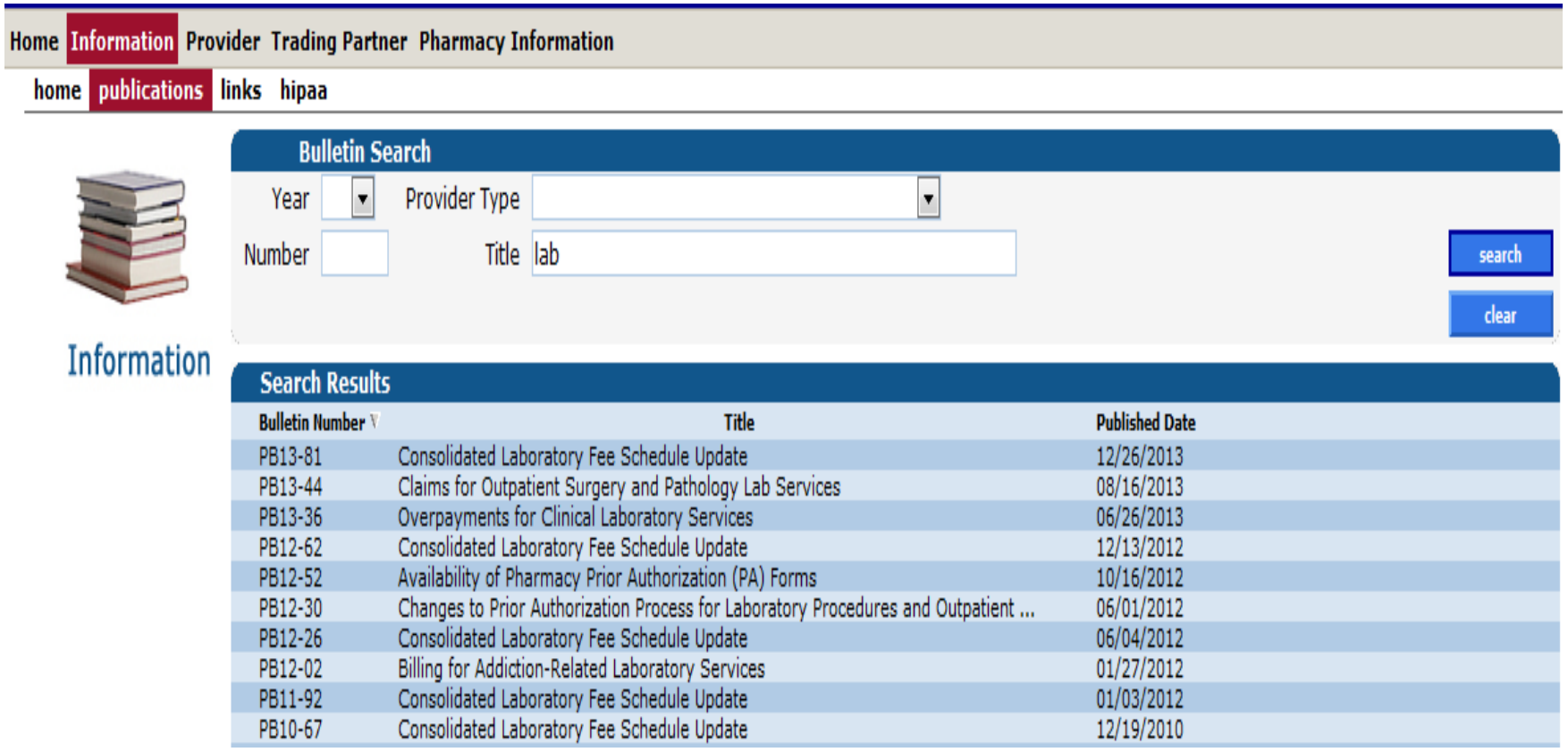
Provider Bulletins

Provider Bulletins – Searching by Year and Type



Provider Bulletins

Provider Bulletins – Searching by Title



- Searching by the word "Lab," only brings up bulletins with the word "Lab" in the title of the bulletin.

Provider Bulletins

Provider Bulletin 2014-29 "Newly Eligible Clients under the Affordable Care Act (Part III)"

- The purpose of this bulletin is to provide additional clarification as well as updated billing and prior authorization guidelines to hospitals rendering services to individuals determined to be newly eligible through Access Health CT (AHCT).

- Hospitals may contact HP to have a temporary client ID issued in the event that an individual presenting an AHCT "Eligibility Decision for Health Care Coverage" notice does not have an eligible client ID in the Automated Eligibility Verification System (AEVS) or the Secure Web portal.

- Temporary IDs will begin with an "8".

Provider Bulletins

Provider Bulletin 2014-29 "Newly Eligible Clients under the Affordable Care Act (Part III)"

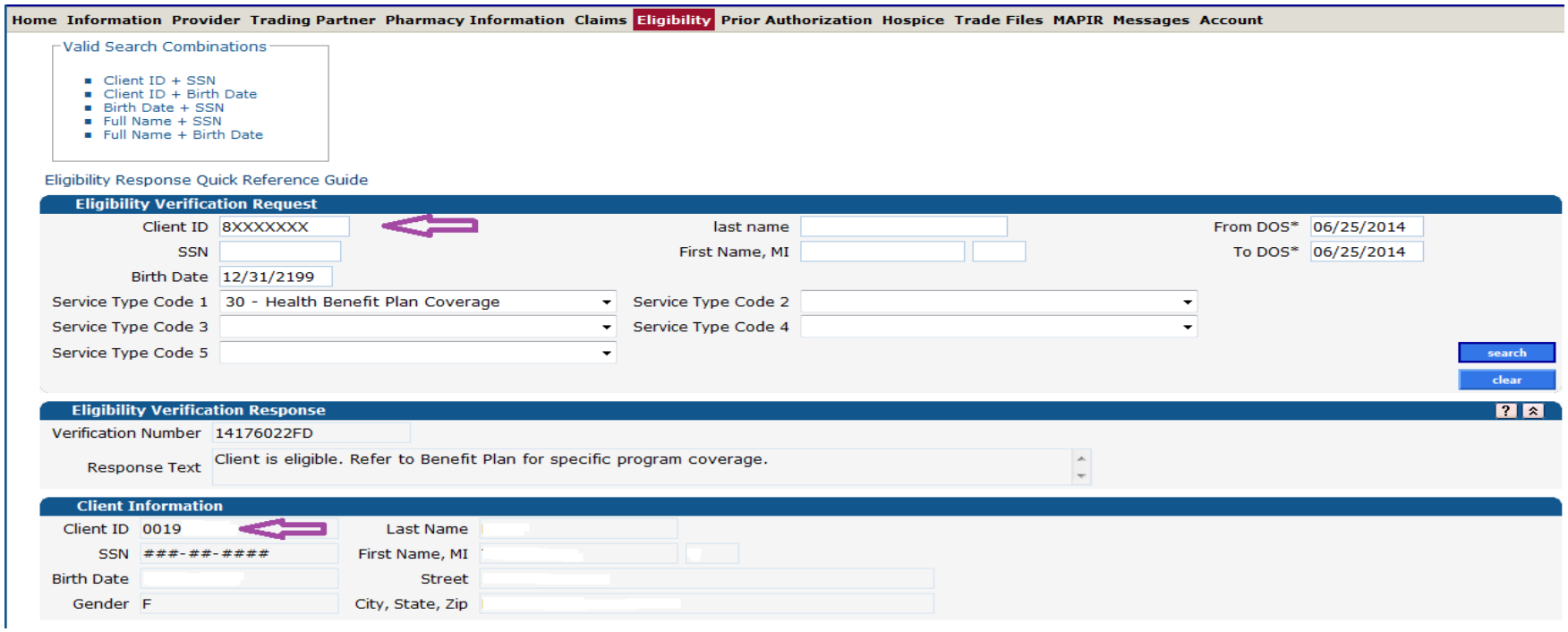
- Hospitals may contact the HP Provider Assistance Center at 1-800-842-8440 and select option #2 "Claim & Enrollment Assistance" from the main menu and then option #4 for "Access Health CT Eligibility".

- This temporary client ID will allow hospitals to submit claims to the Connecticut Medical Assistance Program (CMAP).
  - Except for services that require prior authorization (PA). Services that require PA will deny if submitted with a temporary ID.
  - Hospitals will have to wait until a valid ID is granted, then get PA and once PA is approved the hospital can submit their claims for processing.

Provider Bulletins

Provider Bulletin 2014-29 "Newly Eligible Clients under the Affordable Care Act (Part III)"

- Once the client is granted an active ID, if you perform an eligibility search on the Web using the temporary ID, it will return with the current ID.



Provider Bulletins

Provider Bulletin 2014-29 “Newly Eligible Clients under the Affordable Care Act (Part III)”

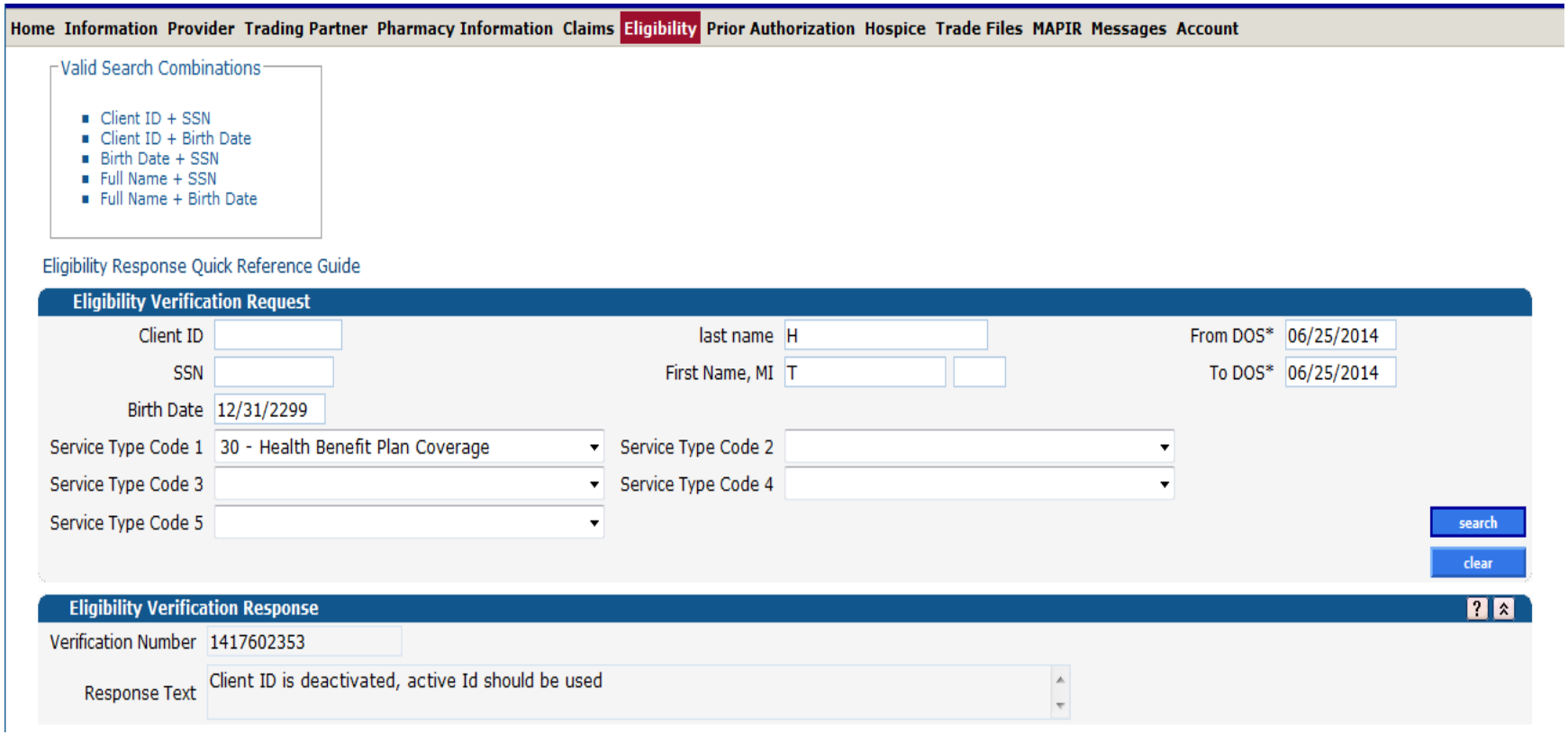
- If you perform an eligibility search on the Web using Full Name and either date of birth or social security numbers and get a response “Client ID is deactivated, active ID should be used.” This means the client has received an active number.

- To get the active number, you might have to change your search, please search using the temporary ID or the client might be loaded with a middle initial. If you do not have a middle initial you will need to contact HP Provider Assistance Center (PAC) for the middle initial.

- Once you have the complete full name, you will be required to perform the eligibility search on the Web again. PAC cannot provide you with the client ID number.

Provider Bulletins

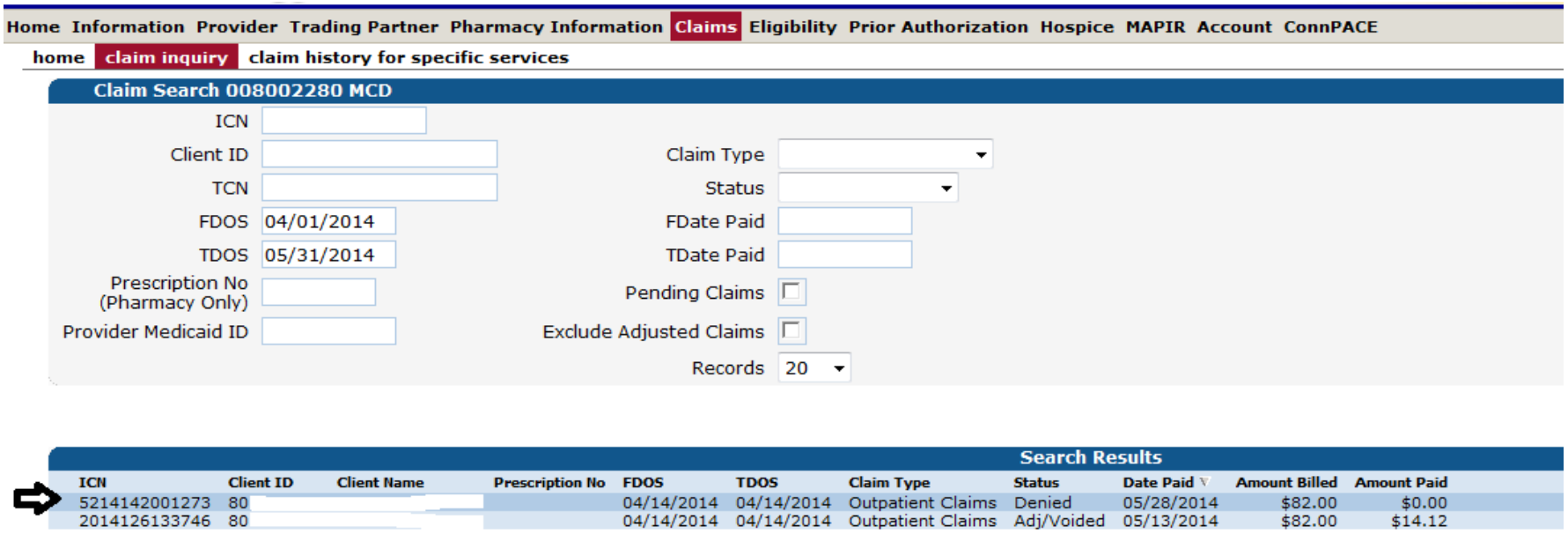
Provider Bulletin 2014-29 “Newly Eligible Clients under the Affordable Care Act (Part III)”



Provider Bulletins

Provider Bulletin 2014-29 "Newly Eligible Clients under the Affordable Care Act (Part III)"

- Claim processed using temporary IDs will be voided once the active ID is granted.
  - Claims with the temporary ID will be voided under ICNs beginning with "52" and EOB code 8231 " Claim Recoupment Due to Voided Payment."



Provider Bulletins

Provider Bulletin 2014-29 “Newly Eligible Clients under the Affordable Care Act (Part III)”

Claim Status Information

Claim Status	DENIED
Claim ICN	5214142001273
Denied Date	05/23/2014
Paid Amount	$0.00
Charter Oak Coinsurance	$0.00
Charter Oak Deductible	$0.00

EOB Information

Detail Number	Code	Description
0	2100	CLIENT NOT FOUND ON ELIGIBILITY MANAGEMENT SYSTEM.
0	9997	REFER TO DETAIL EOB
0	8231	CLAIM RECOUPMENT DUE TO VOIDED PAYMENT.
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
2	9977	PRICING ADJUSTMENT - PROVIDER RCC CUSTOMARY CHARGE PRICING APPLIED

Provider Bulletins

Provider Bulletin 2014-29 "Newly Eligible Clients under the Affordable Care Act (Part III)"

- Once the claim has been voided the claims is then processed under the active ID, with an EOB code 8250 "Claims Reprocessed with EMS recipient ID. Original Claims with AHCT Temp ID Recouped."

Claim Status Information

Claim Status	PAID
Claim ICN	2014153140201
Paid Date	06/06/2014
Paid Amount	$14.12
Charter Oak Coinsurance	$0.00
Charter Oak Deductible	$0.00

EOB Information

Detail Number	Code	Description
0	9997	REFER TO DETAIL EOB
0	8250	CLAIM REPROCESSED WITH EMS RECIPIENT ID. ORIGINAL CLAIM WITH AHCT TEMP ID RECOU
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
2	9977	PRICING ADJUSTMENT - PROVIDER RCC CUSTOMARY CHARGE PRICING APPLIED

Provider Bulletins

Provider Bulletin 2014-06 "Revenue Center Codes (RCC) Requiring a Valid CPT or HCPCS Procedure Code on Outpatient Claims"

- The purpose of this bulletin is to inform hospitals that they are required to bill a valid CPT or HCPCS procedure code when billing a Revenue Center Code (RCC) for dates of service May 1, 2014 and forward on outpatient claims.

- The bulletin provides a list of additional RCCs that began to require CPT/HCPCS procedure codes as of date of service May 1, 2014 and forward.

- On the List of All Revenue Center Codes Requiring CPT/HCPCS Codes those ones highlighted in blue are the RCCs require CPT/HCPCS for dates of service May 1, 2014 and forward.

Hospital Billing Changes

Revenue Center Codes 250, 253, 258-259 and 634-637

- If the hospital is a 340B provider they should continue to bill only with the RCC.

- To determine if a hospital is a 340B hospital, please go to the following Web site and click on the covered entity tab: http://opanet.hrsa.gov/opa/Login/MainMenu.aspx

- Non 340B hospitals should continue following billing instructions found in provider bulletin 2008-35 "National Drug Codes (NDC) Required for Outpatient Hospital Claims due to the Implementation of the Federal Deficit Reduction Act (DRA) of 2005," and Provider Bulletin 2008-42 "Most Frequently Asked Questions related to the billing requirements necessary to support and comply with the implementation of the Deficit Reduction Act (DRA) of 2005," which requires hospitals to bill with NDC and HCPCS codes.

Hospital Billing Changes

Billing with valid CPT or HCPCS procedure code

- As part of the system changes to bill a valid CPT or HCPCS procedure code when billing a Revenue Center Code (RCC), HP has modified their system to ensure more than one detail for the same RCC is payable for those identified RCCs.
  - HP made modifications as of May 1, 2014 to duplicate editing to validate a duplicate service based on the combination of RCC, procedure code and in some instances modifier.

- These system changes will ensure that the payment of these services continues per current Department policies and does not change with the addition of the CPT or HCPCS codes. Refer to the following Scenarios 1-3

- Provider should continue to bill in accordance with CPT/HCPCS coding guidelines.

Hospital Billing Changes

Claim Examples – Scenario 1

- Revenue Center Codes pay a Fixed Fee and maximum units allowed per specific Revenue center codes is >1.

Scenario 1	DOS	RCC	Units	Procedure Code	Billed Amt.	Paid Amt.	EOB
Detail 1	5/1/2014	352	1	72192	$885	$145.46	
Detail 2	5/1/2014	352	1	74150	$873	$145.46	
Total						*$290.92*	

- RCC 352 fixed fee is $145.96 per unit. Hospitals are required to bill each CPT separately on additional detail lines.
- Billed amount should always be the usual and customary amount for each procedure being billed separately.

Hospital Billing Changes

Claim Examples – Scenario 2

- Revenue Center Codes pay at a cost to charge ratio and maximum units allowed per revenue center code is > 1.

Scenario 2	DOS	RCC	Units	Procedure Code	Modifiers	Billed Amt.	Paid Amt.	EOB
Detail 1	5/1/2014	320	1	73030		$114	72.50	
Detail 2	5/1/2014	320	1	73080		$111	70.60	
Total							*$143.10*	

- RCC 320 contract rate is 0.636. Hospital are required to bill each CPT separately on additional detail lines.
- Total payment for RCC 320 ($143.10) does not change based on billing multiple lines with procedure codes.

Hospital Billing Changes

Claim Examples – Scenario 3

- Revenue Center Codes pay at a fixed fee and maximum units allowed per revenue center code = 1

Scenario 3	DOS	RCC	Units	Procedure Code	Modifiers	Billed Amt.	Paid Amt.	EOB
Detail 1	5/1/2014	450	1	99284		$120.00	$120.00	
Detail 2	5/1/2014	450	1	10060		$100.00	$36.82	9994
Detail 3	5/1/2014	450	1	96372		$30.00	$0.00	9994
Total							$156.82	

- RCC 450 fixed fee is $156.82.
- EOB 9994 "Payment Amount Reflects Fixed Fee Allowed Per RCC per date of service" will be applied to all detail lines once the fixed fee is met (Detail 2 and 3).

Hospital Billing Changes

Modifier 27

- Modifier 27 "Multiple Outpatient Hospital E/M Encounters on the Same Date" can be used to identify separate visits in the emergency department on the same day.

- At this time Modifier 27 can only be in connection with RCC codes 450, 456, 510 and 981 and only on a separate encounter/claim on the 2nd encounter.

Claim Detail	DOS	RCC	Procedure Code	Mod	Units	Billed Amt	Paid Amt	Condition Code G0
Encounter 1								
1	6/1/2014	450	99283		1	$356.00	$156.82	N
2	6/1/2014	981	99283		1	$231.80	$91.07	N
Encounter 2								
1	6/1/2014	450	99283	27	1	$356.00	$156.82	Y
2	6/1/2014	981	99283	27	1	$231.80	$91.07	Y

Explanation of Benefit Codes (EOB)

EOB 390 **"Revenue Center Code Requires a HCPC/ Procedure Code"**

- Cause
  - The outpatient hospital claim was billed without a HCPC/CPT code on a Revenue Center Code (RCC) requiring one.

- Resolution
  - Re-submit with a valid HCPC/CPT code. Hospital can refer to the current AMA (American Medical Association) HCPCS and CPT code books for guidance.

Explanation of Benefit Codes (EOB)

EOB 4032 **“Procedure Code not on File”**

- Cause
  - The outpatient hospital claim was billed with an invalid HCPC/CPT code on a Revenue Center Code (RCC) requiring one.
  - This EOB will not hit on RCCs that do not require procedure codes.

- Resolution
  - Re-submit with a valid HCPC/CPT code. Hospital can refer to the AMA HCPCS and CPT code books for valid codes.

Explanation of Benefit Codes (EOB)

EOB 5274 **"ER Professional Services and Clinic Visit cannot be Billed on the Same DOS on the Same Claim"**

- Cause
  - Hospital bills RCC 456 and 981 or RCC 510 and 981 to represent the hospital and professional components on an outpatient claim. In these cases RCC 456 or 510 will pay and 981 will deny as it does today.

- Resolution
  - Claims denied appropriately.
  - If RCC 981 denies with EOB 5274 and RCC 456 or RCC 51X was not present on claim, the hospital would need to verify if this was a 2nd encounter. If 2nd encounter the hospital should add modifier 27 to the RCC 981 detail line. Refer to billing Scenario 4 & 5.

Explanation of Benefit Codes (EOB)

Scenario 4 - **ED / Urgent Care visit and a clinic visit on the same date of service**

Claim Detail	DOS	RCC	Procedure Code	Mod	Units	Billed Amt	Paid Amt	Condition Code G0
Encounter 1								
1	6/1/2013	510	99213		1	196.00	57.23	N
Encounter 2								
1	6/1/2013	450	99284	27	1	$651.00	$156.82	Y
2	6/1/2013	981	99284	27	1	$355.03	$91.07	Y

Scenario 5 - **ED / Urgent Care visit and a clinic visit on the same date of service**

Claim Detail	DOS	RCC	Procedure Code	Mod	Units	Billed Amt	Paid Amt	Condition Code G0
Encounter 1								
1	6/1/2013	450	99284		1	$651.00	$156.82	N
2	6/1/2013	981	99283		1	$355.03	$91.07	N
Encounter 2								
1	6/1/2013	456	99283	27	1	$190.00	$57.23	Y

Medicare Primary Billing

Web claims submission billing Medicare Primary

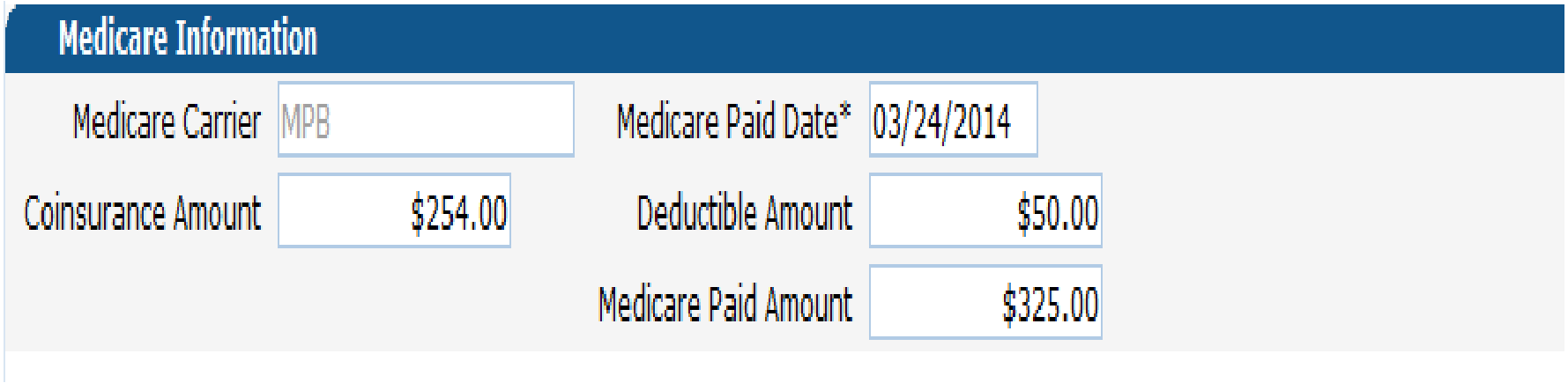
- Medicare Part B Payment – Outpatient Crossover Claim

- The following example illustrates an Outpatient **crossover** claim that contains Medicare Part B coinsurance in the amount of $254.00, Medicare Part B Deductible in the amount of $50.00 and a Medicare paid amount of $325.00.
- Always select Claim Type - Outpatient Xover Claims.
- In the Medicare Information panel you will need to enter the following:
  - In the Coinsurance Amount field enter $254.00.
  - Deductible Amount field enter $50.00.
  - Medicare Paid Amount enter $325.00
- Failure to enter all fields could cause claims denials or duplicate payment.

Medicare Primary Billing

Web claims submission billing Medicare Primary

- Medicare Part B Payment – Outpatient Crossover Claim



- Claims for Managed Medicare or Medicare HMO is handled the same way as Traditional Medicare. If Medicare HMO has a co-pay instead of a coinsurance you will need to enter it in the Coinsurance Amount field.

Medicare Primary Billing

Web claims submission billing Medicare Primary

- Medicare Part A Denial and Medicare Part B Payment - Inpatient
- When Medicare Part A benefits are exhausted, but Medicare Part B makes a payment, the **non-crossover** inpatient claim must be billed by indicating the Part A denial as illustrated in the Medicare Part A denial example on the next slide. The Part B payment must be reflected as an other insurance payment in the TPL panel.
- These claims can be submitted through the secure Web site.
- When submitting a claim on the Web, you will need to first make sure you select the claim type as Inpatient Claim.

Medicare Primary Billing

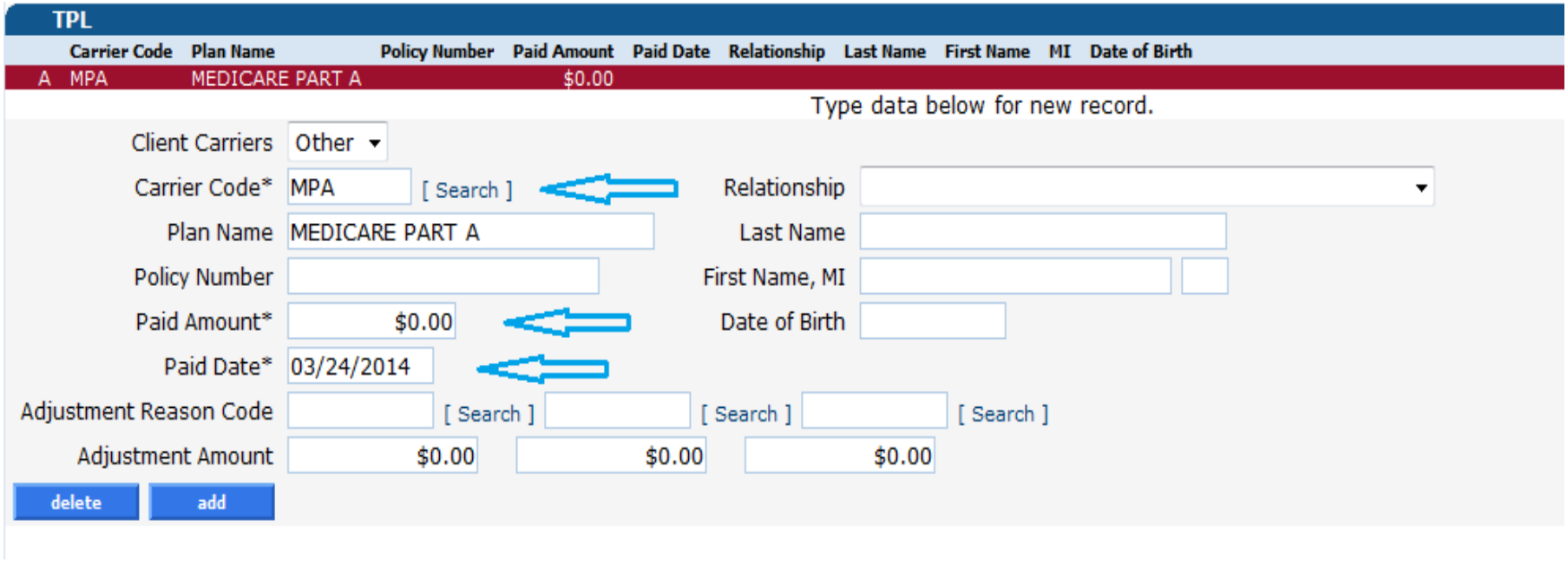
Web claims submission billing Medicare Primary

- Medicare Part A Denial and Medicare Part B Payment – Inpatient

- The Medicare Part A and Medicare Part B entries must be entered in the TPL panel.
  - One entry for the Medicare Part A denial and one entry for the Medicare Part B payment.

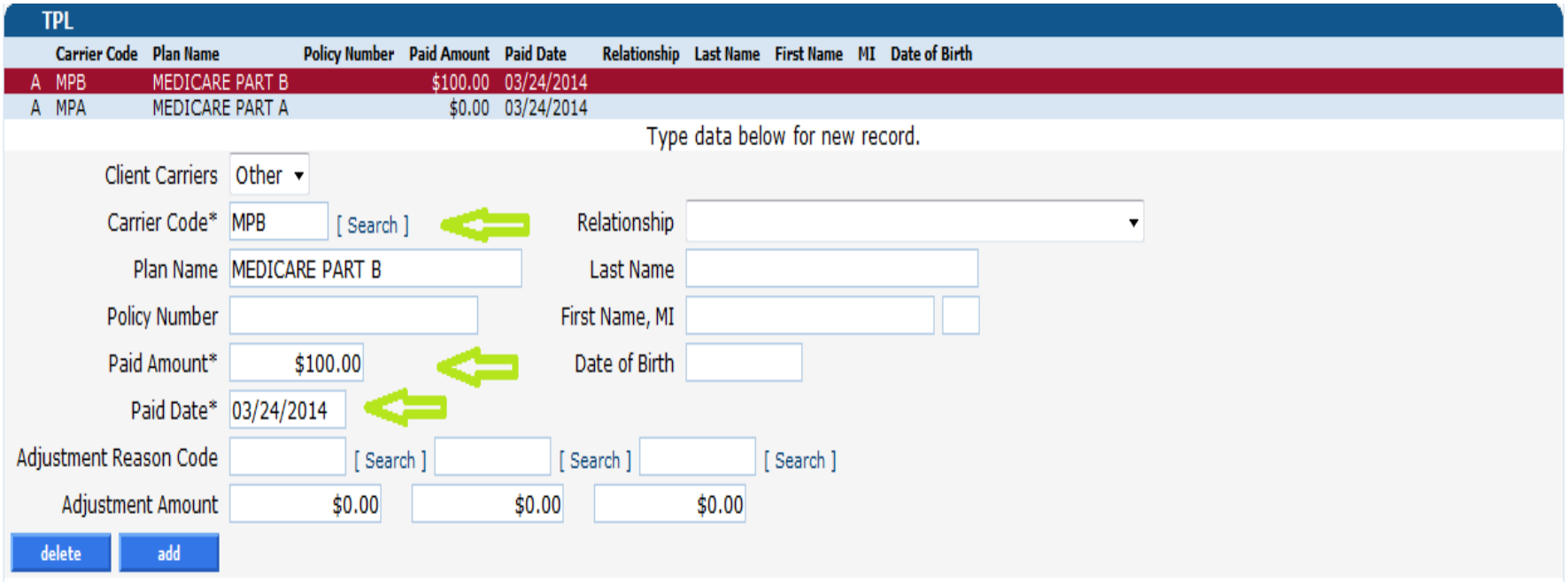
Medicare Primary Billing

- Medicare Part A denial must be entered with carrier code MPA, Paid Amount as $0.00 and the Medicare Part A denial date in the Paid Date field.



Medicare Primary Billing

- Medicare Part B payment must be entered with the Carrier Code as MPB, the Paid Amount field must be equal to the sum of the Medicare paid amount, coinsurance amount (Medicare HMO Co-Pay) and the deductible amount located on the Explanation of Medicare Benefits (EOMB) and enter the Medicare Part B paid date in the Paid Date field.



Enrollment of Residents

Provider Bulletin 2014-48 "Enrollment Requirements of Residents"

- The Affordable Care Act (ACA) requires that ordering, prescribing and referring (OPR) providers who render services to HUSKY clients be enrolled with Medicaid.

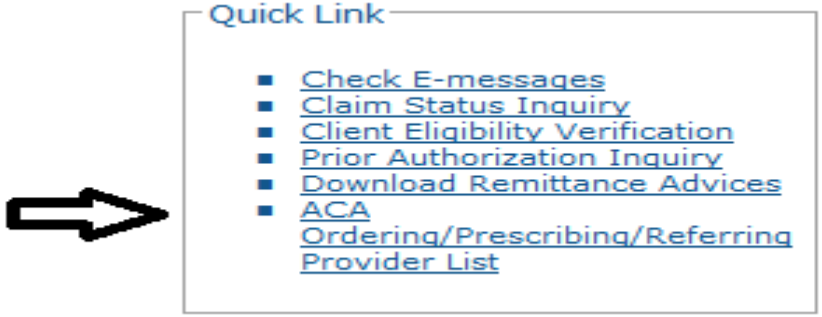
- The Enrollment Wizard on the Web site www.ctdssmap.com has been updated to start accepting enrollment application as of June 25, 2014.

- The resident will have an option to select provider type and specialty. For Provider Type, select "Resident," and then choose either "Medical" or "Dental" for Provider Specialty. Residents will automatically be assigned taxonomy 390200000X (Student/Resident).

Enrollment of Residents

- Step by step enrollment instructions are located on the Home Page on the Web site www.ctdssmap.com, under "Resident Enrollment - Step by Step Instruction Guide" Important Message.

- To verify if the resident is going through enrollment or is already enrolled hospitals can view the list of ordering/prescribing/referring providers on the Home page of the provider's secure Web site at www.ctdssmap.com. Once logged on to the secure site, the link to the list is in the upper right corner under Quick Links.



Enrollment of Residents

- Explanation of Benefits (EOB) 1040 "Ordering/Referring/Attending provider is not enrolled on date of service" will post to claims as a warning only (claims will continue to pay) when the ordering or referring provider is an unlicensed resident who is not enrolled in CMAP for Date of Service (DOS) through September 30, 2014.

- Effective for dates of service October 1, 2014 and forward, Inpatient and Outpatient claims will begin to deny EOB 1035 "Referring provider not enrolled on date of service" on the provider's Remittance Advice (RA), if the referring provider is a resident and is not enrolled in CMAP.

- Residents **are not permitted** to be an attending provider. If the hospital bills a claim with the resident as the attending provider, the claim will deny (EOB) 1042 "Resident not allowed as Attending Provider."

Hospital Modernization Web Page

- In preparation for changes in reimbursement methodology for hospital the Department of Social Services (DSS) and HP are creating a new Web page link titled "Hospital Modernization" on the www.ctdssmap.com Web site for August 1, 2014.

- The changes in reimbursement would affect inpatient claims with admission dates January 1, 2015 and forward and outpatient claims as of January 1, 2016.

- The link will have two options "Inpatient Hospital" and "Outpatient Hospital".

- The Web page will include Quick links, DRG Provider Publications, Hospital FAQ, Hospital Important Message, DRG Calculator, Provider Manual updates and Contact Information.

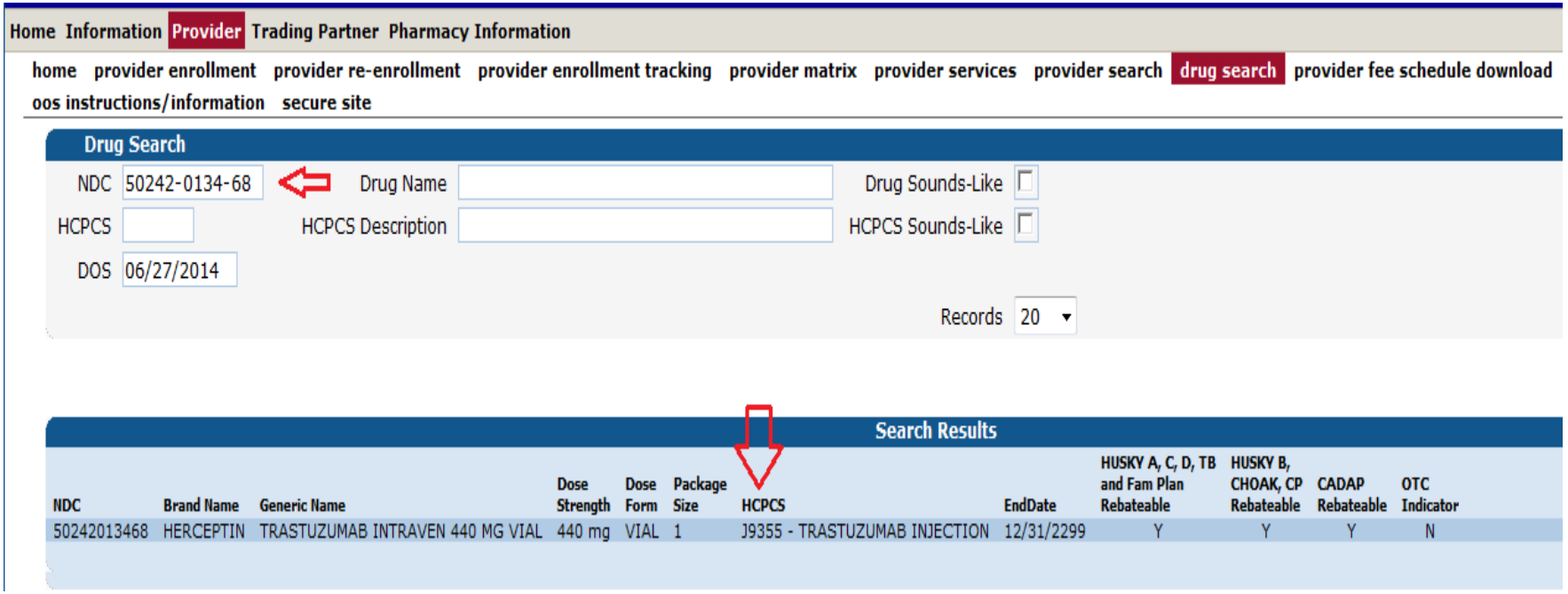
Hospital Modernization Web Page

- The new Web page will be continuously updated throughout the year. Please refer to this page periodically for any updates.

Provider Drug Search

Provider Drug Search On Web site

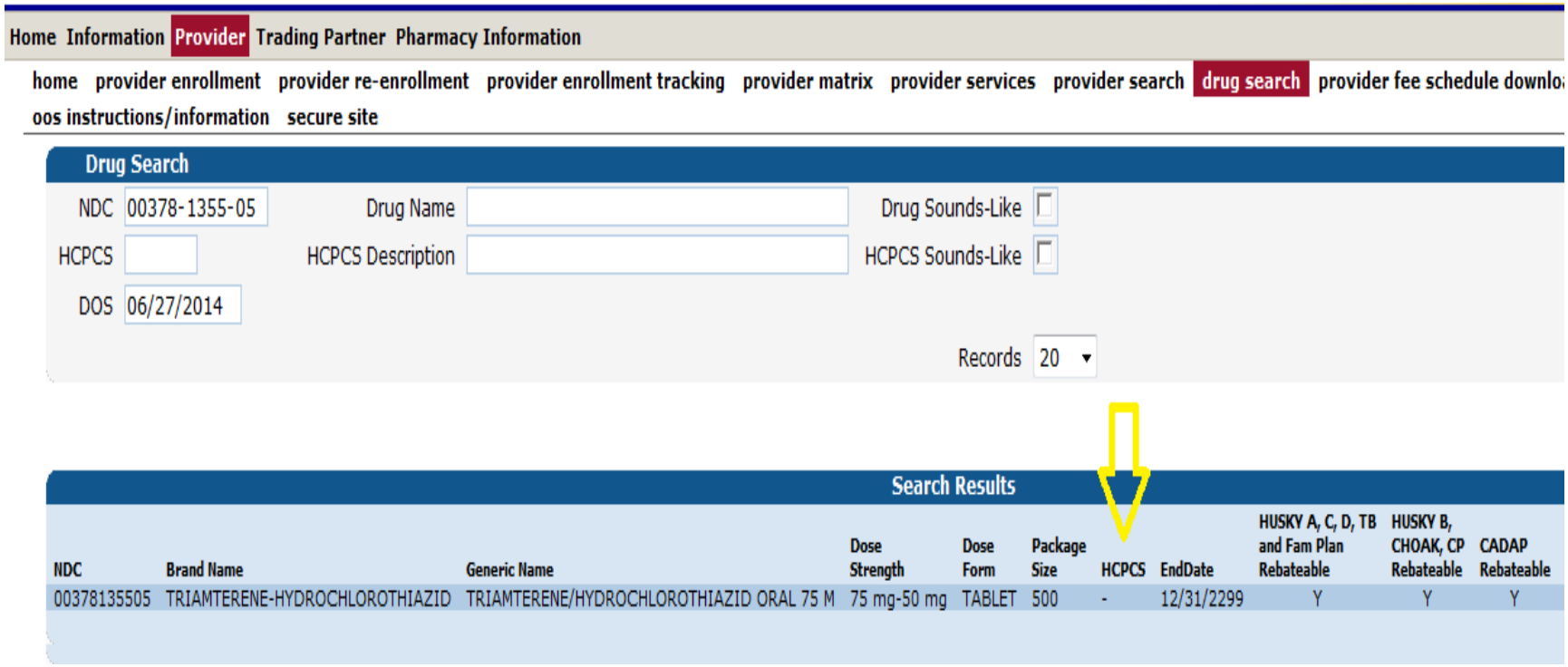
- When billing for National Drug Codes (NDC) on outpatient claims, please refer to the provider drug search on the Web to determine the corresponding HCPCS code. A drug search can be performed at the Web site www.ctdssmap.com, by selecting "Provider" then "Drug Search" and entering the NDC.



Provider Drug Search

Provider Drug Search On Web site

- If the hospital performs a search and no HCPCS comes up, but it is a rebateable NDC, the hospital can bill with one of the following HCPCS codes: J3490, J3590, J9999.



Provider Drug Search

Provider Drug Search On Web site

- Additional information on billing NDCs can be found under provider bulletin 2008-35 "National Drug Codes (NDC) Required for Outpatient Hospital Claims due to the Implementation of the Federal Deficit Reduction Act (DRA) of 2005" and PB 2008-42 "Most Frequently Asked Questions related to the billing requirements necessary to support and comply with the implementation of the Deficit Reduction Act (DRA) of 2005."

ICD-10

ICD-10 Changes Delayed

- On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9 through September 30, 2015.

- On **October 1, 2015** 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.

ICD-10

ICD-10 Consists of Two Parts:

- ICD-10-CM: The clinical modification diagnosis classification system was developed by the World Health Organization (WHO) and the National Center for Healthcare Statistics (NCHS) for use in all U.S. health care treatment settings. (The CM codes increase from 13,000 to 68,000-plus in the ICD-10-CM code set.)

- ICD-10-PCS: The procedure classification system was developed by the Centers for Medicare & Medicaid Services (CMS) for use in the U.S. for inpatient hospital settings only. (There are 71,920 procedure codes in the ICD-10-PCS code set.)

ICD-10

ICD-10 Changes Delayed

- ICD-10 codes must be used on all HIPAA transactions including outpatient and professional claims with dates of service (DOS) and inpatient claims with dates of discharge (DOD) on or after the ICD-10 implementation date.

- Hospitals will be required to split outpatient claims if they overlap October 1, 2015 so all ICD-9 are listed for DOS through September 30, 2015 and all ICD-10 codes are listed for DOS October 1, 2015 and forward.

- Inpatient admissions will not be required to be split if the entire stay overlaps October 1, 2015. All inpatient claims with DOD after October 1, 2015 is billed using ICD-10.

- ICD-10 does not affect CPT coding for outpatient services.

ICD-10

ICD-10 Changes Delayed

- Do make it a point to refer to the **ICD-10 Implementation Information Important Message** from the home page of our Web site www.ctdssmap.com frequently to keep abreast with the most recent ICD-10 developments.

- ICD-10 Testing will still be made available for all hospitals - If you would like to become a beta tester, please e-mail the CMAP testing team at CTICD10testing@hp.com

Hospital Inpatient Payment Changes

- Inpatient hospitals claims with an admission date prior to January 1, 2015 will continue to process using the current payment methodology.

- All Patient Refined-Diagnosis Related Group (APR-DRG) applies to all acute care general hospital inpatient stays with the date of admission on or after January 1, 2015.

- APR-DRG will apply to all inpatient stays in general acute care hospitals, children's hospitals, and out-of-state and border hospitals enrolled in the Connecticut Medical Assistance Program (CMAP).

- Payments based on APR-DRG will to continue to reflect hospital specific base rates.

Hospital Inpatient Payment Changes

- Hospitals will now be required to bill physician services related to inpatient care on a professional claim form.

- Beginning January 1, 2015, all providers who work for or are contracted on behalf of the hospital will be paid via the Connecticut Medicaid physician fee schedule.

- All providers performing these services will need to be enrolled as performing providers in the group the hospital establishes for billing the physician services previously included in the inpatient per diem rate. The physicians associated with these costs are referred to as 'hospital based physicians'.

Hospital Inpatient Payment Changes

- Hospital Based Physician Survey
  - In order to ensure Connecticut hospitals, our enrollment staff and your billing staff are prepared for this transition, we would like your response to the following questions. We recognize that due to the diversity of questions, this may require input from more than one person in your organization. Therefore it is acceptable to complete more than one survey.

- Hospital Based Physician Survey link

www.surveymonkey.com/s/hospbaseprov

Please respond to these questions by July 18th.

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