interChange Provider Important Message

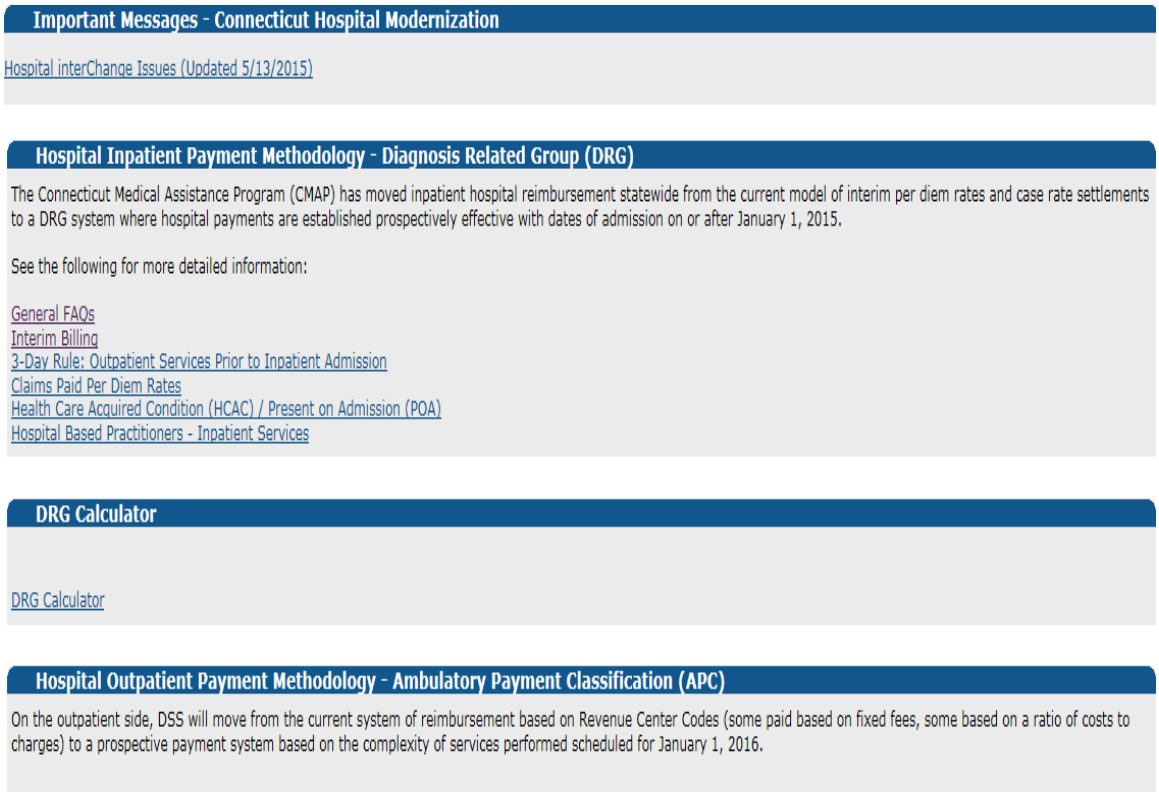
Hospital interChange Updated as of 07/13/2015

*all red text is new for 07/13/2015

Hospital Modernization Web Page

The All Patient Refined-Diagnostic Related Group (APR DRG) inpatient payment methodology was implemented for claims with a date of admission on and after January 1, 2015. DRG pricing now applies to acute care hospital inpatient claims with the exception of chronic disease hospitals, psychiatric hospitals and free-standing birth centers.

The Hospital Modernization Web page on the www.ctdssmap.com Web site was created to assist hospitals with the changes in the reimbursement methodology. The Web page includes the following: Hospital Inpatient Payment Methodology Links, DRG Provider Publications, Hospital FAQs, Hospital Important Messages, DRG Calculator, Provider Manuals and Contact Information.



The following documents were recently updated:

- Provider Manual Chapter 1 – Updated June 2, 2015 the name of DSS' Resources and Recovery Division, DSS' Third Party Liability phone number, and added the Fraud Hotline phone number.
- Provider Manual Chapter 5 – Updated June 2, 2015 inserted current version of (Third Party Liability (TPL) form and updated fax number to submit completed forms to Health management Systems (HMS).
- Provider Manual Chapter 8 – Updated June 24, 2015 with hospital billing changes and Prior Authorization updates.
- Provider Manual Chapter 10 – Updated June 1, 2015 added archived messages and e-mail subscription functionality.

- Provider Manual Chapter 11 – Updated July 1, 2015 procedures for reporting Medicare discrepancies, updated timely filing guidelines and PES reference.

Provider Bulletin 2015-52 - Billing Protocol for Services Provided in Emergency Rooms by Physicians Not Enrolled in Medicaid

The purpose of this provider bulletin is to reiterate to providers that PB 2004-76 "Billing Protocol for Services Provided in Emergency Rooms by Physicians Not Enrolled in Medicaid" is still in effect for claims today. Per the Connecticut Medical Assistance Program provider agreement hospitals are obligated to provide hospital services to Medicaid clients. These services include both the professional and technical components associated with the delivery of services in an emergency room.

Providers that deliver professional services in the hospital regardless of how the claims are billed are required to be enrolled and the hospital is ultimately responsible for the provision of services and under no circumstances should a physician or physician group bill the client directly for those services.

Provider Bulletin 2015-48 – Quantity Modifications for Laboratory Procedure Codes

The purpose of this policy transmittal is to inform all hospital providers that, effective July 1, 2015, the maximum units for select laboratory codes was modified.

In anticipation of the adoption of the Ambulatory Payment Classification (APC) methodology for outpatient hospitals in 2016, the Department modified the maximum allowed units for laboratory codes to be fully in compliance with the NCCI limit. At the same time, the Department aligned the maximum allowed units for laboratory codes when billed by hospitals, independent labs and practitioners.

Effective for dates of service on January 1, 2015 and forward, the maximum units allowed for code G0431 is reduced to one, to reflect the description of this code. HP will identify and systematically reprocess paid claims for code G0431 retroactive to January 1, 2015, reducing the paid units to one. The reprocessing of these claims is tentatively schedule for the first cycle in August.

For more information concerning the National Correct Coding Initiative (NCCI) edits, please refer to PB 2010-57, "CMS National Correct Coding Initiative (NCCI)."

Provider Bulletin 2015-47 – ICD-10 Related Explanation of Benefit (EOB) Codes in Connecticut Medical Assistance Program (CMAP) and Fee Schedule Updates for ICD-10 Diagnosis Codes

The Department of Social Services (DSS) will be implementing certain new EOB codes in CMAP to comply with the ICD-10 mandate. Certain edits for ICD-10 will apply across all claim types, whereas others will be relevant for specific claim types. The bulletin will list the new EOB codes that will set on claims with the implementation of ICD-10 in CMAP.

DSS has also updated references to specific diagnosis codes related to Policy in the Provider Fee Schedule Headers, Footers and Fee Schedule Instructions. These documents now list both ICD-9 and ICD-10 diagnosis codes.

Provider Bulletin 2015-45 – Billing Procedures for Services Ordered by Residents and Interns

The purpose of this provider bulletin is to clarify billing procedures for services that are ordered or prescribed by residents and interns in the hospital setting.

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On claims for services that the resident ordered or referred in the hospital setting, which are performed by hospital staff and billed on behalf of the hospital, either the attending or supervising physician's National Provider Identifier (NPI) may be listed on the claim.

In all situations, the hospital and attending/supervising physicians are responsible for maintaining adequate records to document all orders and referrals, including those issued by residents and documentation confirming which attending/supervising physicians were ultimately responsible for the orders or referrals.

Provider Bulletin 2015-37 – Tobacco Cessation Group Counseling Services

The purpose of this policy transmittal is to:
• Remove PA requirements
• Standardize the maximum group size for counseling sessions
• Clarify covered beneficiaries, facilitator credentials for medical vs behavioral health settings, and the requirements for submission of claims by specific provider types

Tobacco cessation group counseling is a billable service for all HUSKY A, C & D members and for pregnant HUSKY B beneficiaries.

For billing claims in an outpatient hospital setting, Hospitals must use Revenue Center Code 953 and CPT code 99412 on their claims for tobacco cessation group counseling with a tobacco diagnosis as a primary diagnosis in the header.

This policy transmittal supersedes Provider Bulletins 2013-65 and 2014-74 regarding the addition of tobacco cessation group counseling as a Medicaid covered service.

Provider Bulletin 2015-36 – Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule

The Department of Social Services (DSS) and HP are publishing the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and 835 Schedule for the benefit of the provider community for July 2015 – Dec 2015 cycles.

Provider Bulletin 2015-32 – Provider Audit Trainings

The Department is offering free training directed to Connecticut providers in an effort to help them improve compliance with Medicaid requirements under state and federal laws, regulations and policies. This will be done through increased knowledge of audit preparation, the audit process, common errors found during an audit and a discussion of the audit protocols. To view the upcoming training calendar, go to http://www.ctdss.net/osdevents/.

Outpatient Hospital Audit Training is schedule for November 4, 2015 at Connecticut Valley Hospital - Lee Auditorium from 9 AM – 12 PM.

Provider Bulletin 2015-26 – Revised Billing Instructions for Outpatient Claims

In addition, effective for dates of service June 1, 2015 and forward, 340B entities will be required to bill a valid HCPCS procedure code when billing specific pharmacy RCCs 250-253, 258-259 and 634-637 on an outpatient claim. All claim details with these RCCs that are not billed with a valid HCPCS code will deny for EOB 840 – "HCPC Required when Drug Revenue Code is Billed."

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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.

HP is aware that outpatient claim details submitted by 340B hospitals have incorrectly denied for Explanation of Benefit (EOB) codes 861 "NDC is missing or invalid", 841 "Units of measure required for NDC", and 842 "NDC units missing or invalid". 340B hospitals are exempt from the Deficit Reduction Act (DRA) requirements to include the NDC on the UB-04. HP is working to resolve this issue.

HP Reprocessing

In the special mass rate claim adjustment cycle that ran on February 13, 2015, there were claims that did not adjust and pay at the new rate on file. These impacted inpatient claims containing a Revenue Center Codes (RCC), with an updated rate effective for dates of service 11/1/2014 to current, have been adjusted and appear on your June 23, 2015 Remittance Advice with an Internal Control Number (ICN) beginning with region 55.

HP has identified an issue with inpatient claims allowing more days than authorized by the Connecticut Behavioral Health Partnership (CT BHP) for dates of service January 1, 2015 thru April 16, 2015. HP has corrected this issue and the impacted claims were adjusted and appear on your June 9, 2015 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

Eligibility Decision for Health Care Coverage Letters

Please note that individuals can apply for medical coverage for programs other than Medicaid through Access Health CT (AHCT). Only those AHCT letters that state that the individual is approved and has selected HUSKY A or HUSKY D coverage are covered under Medicaid. Individuals who are approved and selected a Qualified Health Plan, are **not** covered under Medicaid. Please note that only HUSKY A and HUSKY D eligible individuals can be granted temporary identification numbers. Hospitals should contact the Access Health CT (AHCT) for additional information on Qualified Health Plan coverage.

Hospitals Enrolled as a Dental Clinic

In order to comply with the American Dental Association's Universal/National Codes, the Department of Social Services is firming up its audit 6148 "Only one restoration per tooth surface allowed per year". Currently, if a restoration procedure code is submitted for a tooth billed with different tooth surfaces, HP edits only on the first tooth surface submitted on the claims in history by the same provider for the same tooth for the same client. Effective June 2, 2015, the editing is done against all tooth surfaces submitted by the provider on the claims in history for the client for the specific tooth.

Implementation of Electronic Messaging - Replacement to the Mailing of Bulletins/Policy Transmittals

DSS is no longer distributing any paper communications to hospitals as of June 30, 2015. You must subscribe to receive CMAP information electronically, such as provider bulletins and policy transmittals, workshop invitations and program updates and reminders.

Additionally, hospitals may refer to Provider Bulletin PB15-23 for complete details on how to enroll or update your electronic notification subscription.

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Please note: Some providers are reporting that the electronic messaging emails are being sent to a recipient's "Spam" or "Junk" email folders. If a provider finds that this is happening, please open the Junk Mail folder and right click on the email from CTDSSMAP@hp.com, next click on "Not Junk" or "Never Block Sender".

Implementation of the ICD-10 Code Sets

The transition to ICD-10 for all providers, payers and vendors will occur on October 1, 2015. Do make it a point to refer to the Important Message frequently to keep abreast with the most recent ICD-10 developments.

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

Please include:
- Trading Partner ID
- NPI and AVRS ID for the claims you will be testing
- 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 add "ICD10 Testing" in the subject of the email