Ambulatory Payment Classification (APC) Scheduled for March 1, 2016

DSS will move from the current system of hospital outpatient payment methodology based on Revenue Center Codes (some paid based on fixed fees, some based on a ratio of costs to charges) to a prospective payment system based on the complexity of services performed. This change is scheduled for March 1, 2016.

In the future, hospitals will be able to refer to the Hospital Modernization Web page on the www.ctdssmap.com Web site for information pertaining to the APC implementation.

Hospital Manual Updates

The following documents were recently updated:

- Provider Manual Chapter 4 - Updated July 23, 2015 Inserted current version of TPL Information form. Updated name of DSS’ Resources and Recovery Division. Removed references to form availability via fax on demand.
- Provider Manual Chapter 5 - Updated July 27, 2015 Removed references to form availability via fax on demand. Inserted current version of the TPL Information Form.
- 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 Bulletin 2015-64 - Billing Requirements to Identify a Distinct/Separate Urgent, Clinic or Emergency Visit

This bulletin is to inform providers that the Department of Social Services (DSS) will be implementing new Explanation of Benefit (EOB) codes in the Connecticut Medical Assistance Program (CMAP) to enforce correct billing requirements to identify a distinct/separate urgent, clinic or emergency visit.

If there are multiple Evaluation and Management (E/M) claims on the same day and the second one does not have a modifier 27 “Multiple Outpatient Hospital E/M Encounters on the Same Date”, the detail will deny with EOB code 5500 “Cannot have Multiple E/M Claims on the Same Date of Service”.

If on an outpatient claim the hospital fails to bill condition code G0 when modifier 27 is used to identify a distinct/separate E/M encounter performed for the same department (i.e. RCC 450/456 emergency room department), on the same date of a separate encounter, then the claim will deny with the following EOB codes:

EOB 5501 - “Condition Code G0 Required when Modifier 27 Billed with an E/M Code” on a current claim or

EOB 5502 - “Previous Claim Required Condition Code G0 when E/M Code is billed with Modifier 27” if the previous claim had a modifier 27, but failed to bill with condition code G0.
Provider Bulletin 2015-64 - Revised Billing Instructions for Outpatient 340B Pharmacies on Outpatient Claims

The purpose of this bulletin is to inform Outpatient 340B Pharmacies that effective for dates of service September 1, 2015 and forward, a valid National Drug Code (NDC) will be required when billing specific pharmacy Revenue Center Codes (RCCs) on an outpatient claim.

Provider Bulletin 2015-61 - Claims Processing Guidance for Implementing ICD-10 Codes

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) will be required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The ICD-10 consists of two parts:

- ICD-10-CM for diagnosis codes
- ICD-10-PCS for inpatient procedure codes. This will impact only Inpatient Hospital claims.

The bulletin gives guidance to providers enrolled in the Connecticut Medical Assistance Program (CMAP) based on claim type and dates of service when ICD-9 vs ICD-10 should be used.

Provider Bulletin 2015-60 - Eligible Clients under the Affordable Care Act Part IV (Temporary ID Update)

The purpose of this provider bulletin is to provide additional clarification as well as updated billing and prior authorization guidelines to providers rendering services to individuals determined to be eligible through Access Health CT (AHCT). This supersedes all previously published bulletins. Also included in the bulletin are examples of Access Health CT (AHCT) approval letters.

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 2015-32 - 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.
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**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.”

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 has resolved this issue as of Wednesday August 26, 2015 and claims can be re-submitted for processing. HP has tentatively scheduled for these claims to be ID & processed in the first claim cycle in September.

HP is aware that some outpatient claim details submitted by 340B hospitals have incorrectly denied for Explanation of Benefit (EOB) codes 5000 “Possible Duplicate of a Paid Claim That is Currently in Process.” HP is working on resolving this issue and will update this message once the issue has been resolved. HP has tentatively scheduled for these claims to be ID & Reprocess in the 2nd claim cycle in September.

**HP Reprocessing**

Effective for dates of service January 1, 2015 and forward, the maximum units allowed for procedure code G0431 - “Drug screen multiple class” is reduced to one, to reflect the description of this code. HP has identified and systematically re-processed paid claims for procedure code G0431 retroactive to January 1, 2015, reducing the paid units to one. The new claims appear on the August 11, 2015 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 27 with an Explanation of Benefits (EOB) code 9991, “Billed Units have been Cutback to Contract Maximum”.

HP has identified an issue with outpatient claims where Revenue Center Code (RCC) 981 denied incorrectly with Explanation of Benefit (EOB) code 5274 “ER Professional Services and Clinic Visit Cannot be Billed on the Same DOS on the Same Claim”. HP has corrected this issue and the impacted claims were adjusted and appeared on your August 25, 2015 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

**Revenue Center Code 68X**

The Department of Social Services (DSS) has removed the requirement for RCC 68X to be billed with a CPT/HCPCS procedure code effective for dates of service September 1, 2015 and forward.

**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 until September 7, 2015.** 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
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- 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

HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) and HP will be closed on Monday, September 7, 2015 in observance of the Labor Day holiday. Both DSS’ and HP’s offices will re-open on Tuesday, September 8, 2015.