interChange Provider Important Message

Hospital Monthly Important Message Updated as of 01/11/2021

*all red text is new for 01/11/2021

CMAP Addendum B January 2021

The Department of Social Services (DSS) will be updating the Connecticut Medical Assistance Program (CMAP) Addendum B to incorporate the 2021 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) for dates of service January 1, 2021 and forward to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system on December 31, 2020 with a January 1, 2021 effective date for dates of service January 1, 2021 and forward. Gainwell Technologies has determined there were no outpatient claims that processed with the incorrect payment for dates of services January 1, 2020 and forward.

Due to the delay in receiving the Centers for Medicare and Medicaid Services (CMS) Addendum B files, DSS is unable to update the claims processing system by January 1, 2021. Any procedure code that is "NEW", changed or deleted will be updated in the near future. A separate communication will go out once the system has been updated.

For dates of service January 1, 2021 and forward the outlier dollar threshold has increased from $5,075.00 to $5,300.00.

DRG Calculator

The DRG Calculator was updated and added to the Hospital Modernization Web Page effective for dates of discharge January 1, 2021 and forward.

The DRG Calculator has been updated to reflect the DRG Weights, Average Length of Stays (ALOS) and Outlier Thresholds effective for discharge dates January 1, 2021 and forward. These updates are located under the DRG Table tab in the DRG Calculator. DSS has updated the hospital's Adjusted Base Rate, IME Factor, Cost-to-Charge ratio, Behavioral Health and Rehab per diem rates for discharge dates January 1, 2021 and forward. These updates are located under the Provider Table CT tab in the DRG Calculator.

CMAP Addendum B October 2020

An updated PDF and Excel version of CMAP Addendum B V21.3 has been approved by the Department of Social Services (DSS) and has been added to the Hospital Modernization page on the www.ctdssmap.com Web site.

These changes are effective for dates of service October 1, 2020 and forward. Any procedure code that is "NEW", changed or deleted with an effective date of October 1, 2020 was updated on November 11, 2020. Outpatient and outpatient crossover claims impacted by Ambulatory Payment Classification (APC) weight changes, status indicator changes, and other changes indicated by an "X" in the change field on the CMAP Addendum B with dates of services between October 1, 2020 to November 11, 2020 that were processed prior to the availability of the Addendum B updates were adjusted in the December 18, 2020 claim cycle and the adjusted claims appeared on the December 22, 2020 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 55.

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DRG Inpatient Claims Reprocessing

Any inpatient claims with dates of discharges between October 1, 2020 to November 11, 2020 that were processed prior to the availability of the new grouper version updates and processed at a different DRG code were adjusted in the December 18, 2020 claim cycle and the adjusted claims Appeared on the December 22, 2020 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 55.

Provider Bulletins

Provider Bulletin 2020-101 - Updated Billing Guidance for Cystic Fibrosis and Spinal Muscular Atrophy Testing

The Department of Social Services (DSS) has updated its prior authorization requirements related to Cystic Fibrosis (CF) and Spinal Muscular Atrophy (SMA) testing effective for dates of service January 1, 2021 and forward.

Hospitals should refer to Table 11 under the DSS Fee Schedule Instructions which lists all the ICD-10-CM diagnosis codes that override the PA requirement for CF testing and Table 11 A for SMA testing.

Table 11 and Table 11A under the Fee Schedule Instructions can be accessed by going to the CMAP Web site: www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download", click "I accept", and then at the top of the page select "***Click here for the Fee Schedule Instructions***"

Provider Bulletin 2020-100 - Telemedicine: Update to Place of Service Requirements

Effective for dates of service January 1, 2021 and forward, telemedicine claims should no longer be billed with POS 02. Providers billing for telemedicine services must indicate the POS that best describes where the service would have been rendered if the service was performed in-person. All claims for services performed via telemedicine must continue to be billed with either modifier 95 which is used when the member is located at home or GT which is used when the originating site of the member is located in a healthcare facility or office.

Provider Bulletin 2020-89 - Annual Update to the Inpatient Hospital Adjustment Factors and Update to the APR-DRG Weights

This policy transmittal is to inform providers that, effective for inpatient hospital discharges on or after January 1, 2021: (1) the adjustment factor added to the All Patient Refined – Diagnosis-Related Group (APR-DRG) base payment calculation will be updated for calendar year (CY) 2021 in accordance with the existing approved methodology and (2) the traditional Healthcare Cost and Utilization Project (HCUP) weights established by 3M will be implemented for APR-DRG. The DRG calculator was updated with these amounts and is currently posted to the Hospital Modernization Web page.

Provider Bulletin 2020-87 - CMAP COVID-19 Response – Bulletin 44: Updated Telemedicine Guidance for Physical Therapy and Occupational Therapy Services

Outpatient hospitals and chronic disease hospitals may render PT and OT procedure codes listed in the provider bulletin via telemedicine (real time live audio and video technology) when clinically appropriate. Outpatient hospitals and chronic disease hospitals must continue to follow the CMAP Addendum B regarding reimbursement for PT and OT services and bill with the appropriate Revenue Center Codes (RCCs).

PT and OT services are paid as an all-inclusive rate to the hospital and professional services cannot be billed separately.

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Provider Bulletin 2020-84 - CMAP COVID-19 Response - Bulletin 42: Clarifying Guidance for Speech and Language Pathology Telemedicine Services Stated in PB 2020-23 and 2020-24

As stated in Provider Bulletin (PB) 2020-23 and PB 2020-24, effective for dates of service March 20, 2020 until DSS has notified providers in writing that the state has deemed COVID-19 no longer to be a public health emergency, the following Speech & Language Pathology (SLP) procedure codes may be rendered via telemedicine; 92507, 92521, 92522 and 92523.

During the Temporary Effective Period, DSS is adding Revenue Center Code (RCC) 444 – "SLP Evaluation and Re-evaluation" as an allowable telemedicine service. RCC 444 must be billed with an applicable procedure code also approved to be rendered via telemedicine

Provider Bulletin 2020-82 - Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)

The Department of Social Services (DSS) and Gainwell Technologies have published the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and 835 schedule for January 2021 to June 2021.

Provider Bulletin 2020-79 - Removal of Prior Authorization from Electroconvulsive Therapy Services

Effective for dates of service January 1, 2021 and forward, the Department of Social Services (DSS) is removing Prior Authorization (PA) on procedure code 90870 "Electroconvulsive therapy" that is listed on the Clinic and Outpatient Hospital Behavioral Health fee schedule and on the CMAP Addendum B.

Hospitals must continue to refer to both CMAP Addendum B and the Clinic and Outpatient Hospital Behavioral Health fee schedule for PA requirements

Reminders:

Hospital Outpatient Flat Fee Schedule

Effective for dates of service January 1, 2021 and forward, DSS has updated the hospital outpatient flat fee rates and the hospital outpatient flat fee schedule will be updated in the near future.

The Hospital Outpatient Flat fee schedules can be accessed and downloaded from the Connecticut Medical Assistance Program Web site www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download". Click on the "I accept" button and proceed to click on the Hospital Outpatient Flat Fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open."

Status Indicator G "Drug Biological Pass Through" and K "Non-Pass-Through Drugs and Biologicals"

If the procedure codes payment type is APC-PR with a status indicator of G or K, it will be reimbursed based on the payment rate on CMAP Addendum B x the number of units up to the detail billed charges. We will pay the lesser of billed charges and the payment rate. We only allow more than the detail amount when the claims process at an APC rate.

Explanation of Benefit (EOB) Code 4742 - The Procedure is Not Consistent with the Header Diagnosis Based on the Client's Benefit Plan

Cause: Procedure code billed is not covered under the client's benefit plan based on the diagnosis being billed.

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Resolution: Verify the diagnosis code submitted on the claim. If it is incorrect, correct the claim and resubmit. If the diagnosis code on the claim is correct, based on the diagnosis it is not a payable service under the client's benefit plan (i.e. Family Planning benefit plan).

Medically Unlikely Edits (MUEs)

MUE updates are not published on the www.ctdssmap.com Web Site and providers are asked to refer to the National Correct Coding Initiative (NCCI) Edit files by clicking on the link below to obtain published quarterly additions, deletions, and revisions to MUE values and Procedure-to-Procedure (PTP) edits:
https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

Please refer to provider bulletin 17-69 "National Correct Coding initiative (NCCI) - Medically Unlikely Edits Review Process" for additional information.

Billing of Influenza Vaccines for the 2020-2021 Influenza Season Important Message

Gainwell Technologies would like to remind hospitals of the importance of reporting the correct Healthcare Common Procedure Coding System (HCPCS) code for each vaccine product being billed to the Connecticut Medical Assistance Program (CMAP). If the 11-digit National Drug Code (NDC) reported on the claim does not correspond to the vaccine code reported on the same claim detail, the vaccine will be denied. As a reminder, hospitals are asked to submit the Outer Carton NDC when billing vaccine products.

Please refer to the important message from the home page at www.ctdssmap.com for additional links and resources to assist hospitals with selecting the correct HCPCS code for each vaccine billed.

COVID-19 (Coronavirus) Information and Frequently Asked Questions (FAQs) (Updated 12/23/2020) Important Message

The FAQ document is located on the www.ctdssmap.com Web page on the home page under Important Messages.

Appendix 1 - This spreadsheet lists the procedure codes, and when applicable the revenue center codes that are eligible to be billed when performed as via telemedicine (synchronized audio and visual) or telephonically (audio-only) during the Temporary Effective Period in response to COVID-19. Hospitals must refer to the corresponding provider bulletins for billing guidance, including effective dates and applicable fee schedules. Hospitals must continue to follow CMAP Addendum B regarding reimbursement.

Provider Assistance Center (PAC)

If hospitals are experiencing extended call wait times, hospitals may email the provider assistance call center with their question at ctdssmap-provideremail@dxc.com. Please be sure to include your name and phone number with your inquiry.

Hospitals who wish to submit Hysterectomy Consent Forms, Sterilization Consent Forms or Electronic Claim Attachments may fax the documents to 1-860-986-7995 or email them to ctxix-claimattachments@dxc.com.

Hospitals who wish to submit Trauma Questionnaire Responses may fax them to 1-833-577-3519 or email them to CTXIX-TraumaMailbox@dxc.com.

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TPL Audit Report - January 2021

The Third-Party Liability (TPL) Audit reports were sent to the following hospitals on January 1, 2021:

Stamford Hospital, Saint Francis Hospital and Medical Center, The Hospital of Central Connecticut, Midstate Medical Center, and Lawrence and Memorial Hospital.

HOLIDAY CLOSURE

Please be advised, the Department of Social Services (DSS) and Gainwell Technologies will be closed on Monday, January 18, 2021 in observance of the Martin Luther King Jr.'s Day Holiday. DSS and Gainwell Technologies offices will re-open on Tuesday, January 19, 2021

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