interChange Provider Important Message

Hospital Monthly Important Message Updated as of 02/08/2021

*all red text is new for 02/08/2021

CMAP Addendum B January 2021

The Department of Social Services (DSS) has updated 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).

An updated PDF and Excel version of Connecticut Medical Assistance Program (CMAP) Addendum B V22.0 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.

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.

Any procedure code that is "NEW", changed or deleted is tentatively scheduled to be updated on February 10, 2021. Any claims with new or changed procedure codes are tentatively scheduled to be identified and reprocessed in the 2nd cycle in March.

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.

Inpatient Claims Suspending

The update to the ICD-10 (International Statistical Classification of Diseases) diagnosis codes effective January 1, 2021 (E.g. M35.81 "Multisystem inflammatory syndrome") has caused inpatient Diagnostic Related Group (DRG) claims with header Through Date of Service (TDOS) January 1, 2021 and forward to suspend with either Explanation of Benefit (EOB) code 0693 "Invalid Principal Diagnosis" or EOB code 0920 "3M Grouper Error." The hospital important message will be updated once the claims have been released for processing.

Present on Admission (POA) Indicator

Gainwell Technologies identified an issue with inpatient claims denying for Present on Admission (POA) indicator when the hospital billed for diagnosis code Z11.52 and Z86.16 and the POA indicator was blank. The diagnosis codes have been corrected and are now exempt from requiring a POA indicator and any inpatient claims that denied for EOB code 752 "Present on Admission Indicator Missing or Invalid" can be re-submitted for processing.

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Provider Bulletins

Provider Bulletin 2021-11 - 2021 Revision of Rates for Certain Clinical Diagnostic Laboratory Testing Codes

Effective for dates of service retroactive to January 1, 2021 and forward, the Department of Social Services (DSS) is adjusting the reimbursement for the following clinical diagnostic laboratory services:

Procedure Code	Rate
81316	$145.12
81542	$2,711.10
81552	$5,443.20
81554	$3,850.00
85400	$5.40
89329	$13.71
Q0113	$2.99

Provider Bulletin 2021-05 - CMAP COVID-19 Response Bulletin 48: COVID-19 Vaccine Administration – Medical Practitioners

Effective for dates of service as specified below, until the Department of Social Services (DSS) has notified providers in writing that the state has deemed COVID-19 to no longer be a public health emergency, the following COVID-19 vaccine administration procedure codes 0001A, 0002A, 0011A and 0012A will be eligible for reimbursement for HUSKY Health members (A, B*, C and D) at 100% of the Medicare rate.

Reimbursement to Outpatient Hospitals that have registered with the CT DPH to administer the COVID-19 vaccine will be based on the reimbursement for each specified vaccine administration procedure code as set forth in CMAP Addendum B. Please note that when the vaccine administration is provided in the outpatient hospital setting and the outpatient hospital bills for the administration, there will be no separate reimbursement for professional services.

Updated billing instructions:
A claim submitted for the administration of a COVID-19 vaccine must include both the procedure code (0001A, 0002A, 0011A and 0012A) for the administration with Revenue Center Code 770 "Prevent Care Svs" and the procedure code for the vaccine product administered 91300 or 91301 (including the national drug code - NDC); otherwise, the detail for the administration will deny.

Provider Bulletin 2021-03 - Policy Updates and Changes to Clinical Review Criteria – Eteplirsen, Golodirsen, and Viltolarsen, Bone Anchored Hearing Aids, and Compression Garments and Removal of Prior Authorization for Supprelin LA

The purpose of this bulletin is to notify enrolled Connecticut Medical Assistance Program (CMAP) providers of upcoming policy updates and changes to clinical review criteria for certain medical services and the removal of the prior authorization (PA) requirement for Supprelin LA.

Prior authorization for Supprelin LA will no longer be required effective for dates of service February 1, 2021 and forward.

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Provider Bulletin 2020-102 - CMAP COVID-19 Response – Bulletin 47: Updated Billing Guidance Regarding High-Throughput Technology Billed Under Procedure Codes U0003 and U0004

The Department of Social Services (DSS) has updated the reimbursement for clinical diagnostic laboratory tests (CDLTs) for the detection of SARS-CoV2. Reimbursement for high throughput tests billed with procedure codes U0003 and U0004 will be priced at $75.00; and add-on procedure code U0005 will be added to the laboratory fee schedule and priced at $25.00.

The add-on code U0005 was created to be billed in combination with procedure codes U0003 or U0004 only when providers meet the specific criteria outlined by CMS. Please refer to the provider bulletin for more information on when to bill with the add-on code.

Reminders / Updates:

Clarification: Procedure codes; 90632, 90634, 90636, 90658, 90690, 90691, 90702, and 90717

For dates of Service January 1, 2017 and forward the following procedure codes; 90632, 90634, 90636, 90658, 90690, 90691, 90702, and 90717 when considered as a packaged service will be paid based on the fee schedule and will no longer be processed as part of the APC payable service. As a reminder, all Outpatient claims are subject to APC editing and if a procedure code is submitted without an APC payable service, the claim will be denied with EOB code 309 "APC – Only Incidental Services Reported."

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 schedule 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."

1099s Now Available on Web site

Hospitals are reminded they can download their 2020 1099s from the www.ctdssmap.com Web site. This functionality is available for all Master Users and any subordinate clerk accounts who have access to download PDF Remittance Advice files. The 2020 1099s were also mailed to hospitals on January 27, 2021.

Hospitals wishing to download their 2020 1099 from www.ctdssmap.com would do so by logging into their secure Web portal account, selecting Trade Files then download. Hospitals must then click on the 1099s selection located at the top of the drop-down menu.

The retention period for 1099s on the secure Web portal account is three (3) years. Hospitals are encouraged to download and save a local copy of the 1099s as after three (3) years, the downloadable files will be removed and no longer available.

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.

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Provider Manual Chapter 12

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.

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).

COVID-19 (Coronavirus) Information and Frequently Asked Questions (FAQs) - (Updated 2/5/2021) 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.

TPL Audit Report - February 2021

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

Bridgeport Hospital, Bristol Hospital, Johnson Memorial Hospital and The Charlotte Hungerford Hospital.

HOLIDAY CLOSURE

Please be advised, the Department of Social Services (DSS) will be closed on Friday, February 12, 2021 in observance of Lincoln's Birthday. In addition, DSS and Gainwell Technologies will be closed on Monday, February 15, 2021 in observance of the Presidents' Day holiday. Both DSS and Gainwell Technologies offices will re-open on Tuesday, February 16, 2021