interChange Provider Important Message

Hospital Monthly Important Message Updated as of 03/08/2021

*all red text is new for 03/08/2021

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 "NEW" procedure code that was updated on February 10, 2021 are tentatively scheduled to be identified and reprocessed and will appear on the March 16, 2021 Remittance Advice (RA) with an Inter Control Number beginning with 61. Any outpatient claims with procedure codes that were changed or deleted 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.

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") previously 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." This issue was corrected, and the suspended claims will be processed in the March 12, 2021 claim cycle and will appear on the March 16, 2021 RA.

Inpatient Claims Missing DRG Information

Gainwell Technologies identified an issue with inpatient claims processed between January 27, 2021 and February 3, 2021 that were missing the DRG code on the claim. Gainwell Technologies has corrected the issue and the identified claims were adjusted and will appear on the hospital's March 16, 2021 RA with an Internal Control Number (ICN) beginning with 52.

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 were corrected on February 3, 2021 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 2021-12 - CMAP COVID-19 Response Bulletin 50: Telemedicine Guidance for Respiratory Care Services

Effective for dates of service retroactive to February 1, 2021 and until the Department of Social Services (DSS) has notified providers in writing that the state has deemed COVID19 to no longer to be a public health emergency, respiratory care services will be allowed to be rendered via synchronized telemedicine (real time live audio and video technology) when the services are medically necessary and telemedicine is clinically appropriate. When respiratory care practitioners render respiratory care services procedure codes 94664 "Nebulizer eval & education" and 94667 "Chest PT" via telemedicine (real time live audio and video technology) in the outpatient hospital setting or in outpatient chronic disease hospitals (CDHs), the outpatient hospital or CDH may bill for the services rendered by the respiratory care practitioners with the appropriate telemedicine modifier.

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.

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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:

Prior Authorization Grid for Outpatient Hospitals

The prior authorization grid for outpatient hospitals has been updated and can be accessed via the www.ctdssmap.com Web site by selecting the "Hospital Modernization" Web page. The prior authorization grid is located under "Important Messages – Connecticut Hospital Modernization.

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 those procedure codes are 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.

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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.

Provider Manual Chapter 12

Explanation of Benefit (EOB) Code 5454 - COVID 19 Admin Must be Billed with COVID 19 Vaccine

Cause: A claim was submitted with procedure code 0001A, 0002A, 0011A, 0012A or 0031A without the procedure code for the vaccine product administered, including the National Drug Code (NDC).

Resolution: Verify the coding on the claim and re-submit the claim.

Explanation of Benefit (EOB) Code 5455 - APC – COVID 19 Lab Add-On Code Reported W/O Primary Proc

Cause: An outpatient claim was submitted with procedure code U0005 without one of its primary procedure U0003 or U0004 on the same date of service.

Resolution: Verify the coding on the claim and re-submit the claim.

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 3/3/2021) Important Message

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

Janssen COVID-19 Vaccine

The Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) for emergency use of the Janssen COVID-19 Vaccine for the prevention of Coronavirus Disease 2019 (COVID-19) for individuals 18 years of age and older, as described in the Scope of Authorization (Section II), pursuant to Section 564 of the Federal Food, Drug, and Cosmetic Act (the FD&C Act or the Act) (21 U.S.C. 360bbb-3).

The addition of the single dose Janssen COVID-19 Vaccine expands the number of authorized COVID-19 vaccines to three (3).

A separate notification will go out when CMAP Addendum B is updated and the system is ready to accept these claims submitted with the Janssen COVID-19 vaccine. Any outpatient claims submitted prior to the update will be denied and the hospital will be required to re-submit the claim.

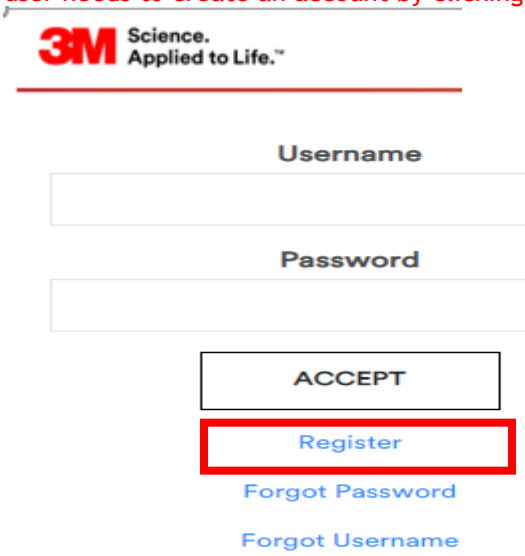
Once approved COVID-19 vaccine must include both the procedure code 0031A for the administration with Revenue Center Code 770 "Prevent Care Svs" and the procedure code for the vaccine product

administered 91303 (including the national drug code - NDC); otherwise, the detail for the administration will deny.

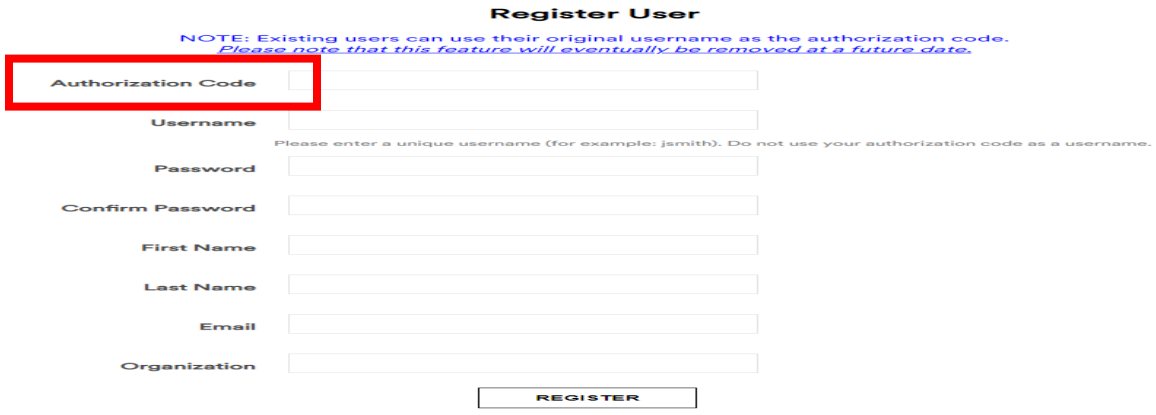
Appendix 1 - This spreadsheet lists the procedure codes, and when applicable the revenue center codes that are eligible to be billed when performed as via telemedicine (synchronized audio and visual) or telephonically (audio-only) during the Temporary Effective Period in response to COVID-19. Hospitals 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.

3M Health Information Systems Tool – www.aprdrgassign.com

3M has just rolled out an update to the Web site which includes new features and functionality, as well as a new login process. User information was not migrated over from www.aprdrgassign.com. Every user needs to create an account by clicking the Register link.



For existing users, Authorization Code is the original username for aprdrgassign.com. For CT hospital users the original username was **CTHosp**. All fields must be populated.



After pressing the [REGISTER] button, a verification email will be sent. Open the email and click the link in the email body to complete the registration process. You will not be able to log-in before verifying your email.

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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 – March 2021

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

William W. Backus Hospital, Prospect Manchester Hospital, and Bridgeport Hospital