interChange Provider Important Message

Hospital Monthly Important Message Updated as of 03/11/2020

*all red text is new for 03/11/2020

CMAP Addendum B January 2020

The Department of Social Services (DSS) will be updating the Connecticut Medical Assistance Program (CMAP) Addendum B to incorporate the 2020 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) for dates of service January 1, 2020 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 January 2, 2020 with a January 1, 2020 effective date for dates of service January 1, 2020 and forward. DXC Technology has determined there were no outpatient claims that processed with the incorrect payment for dates of services January 1, 2020 and forward.

Any other procedure code adds, changes or deletes with an effective date of January 1, 2020 and forward were updated on January 28, 2020. Any outpatient claims processed between January 1, 2020 and January 28, 2020 with APC weight changes and status indicator changes on the CMAP Addendum B were adjusted in the February 21, 2020 claim cycle and appeared on the February 25, 2020 Remittance Advice with an Explanation of Benefit (EOB) code 8182 "Claim Mass Adjusted Due to an APC Change". Any outpatient claims with "NEW" procedure codes were adjusted and re-processed can be identified by Internal Control Number (ICN) beginning with 61 the February 25, 2020.

Procedure codes 78431-78433 were recently updated on CMAP Addendum B. The payment type was updated on CMAP Addendum B and will now process based on the rate listed on the physician radiology fee schedule. Procedure codes J1729, J7340, J8610 and Q2009 were recently updated to pay at the payment rate posted on CMAP Addendum B.

Provider Bulletin 2020-05 - Increasing the Reimbursement Rates for Select Long-Acting Reversible Contraceptive Devices

DSS has updated the reimbursement rates for select Long-Acting Reversible Contraceptive (LARC) devices. Effective for dates of service March 1, 2020 and forward, DSS increased the reimbursement rates for the following LARC devices on the physician office and outpatient fee schedule procedure code J7297 "Liletta, 52 mg" and J7300 "Paragrad" and on the family planning clinic fee schedule procedure code J7297 was updated. The reimbursement rates for LARCs on the family planning fee schedule is based on 340-B pricing.

Hospital Outpatient Flat Fee Schedule

Effective for dates of service January 1, 2020 and forward, DSS has updated the hospital outpatient flat fee rates and the hospital outpatient flat fee schedule was updated on February 10, 2020.

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."

Rate Type "DEF" is nongovernmental licensed short-term general hospitals and rate type "RCC" is for all other hospitals and out-of-state and border hospitals.

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1099s Now Available on Web site

DSS and DXC Technology are pleased to announce providers can download their 2019 1099s from the www.ctdssmap.com Web site. This functionality will be available for all Master Users and any subordinate clerk accounts who have access to download PDF Remittance Advice files. The 2019 1099s were also mailed to providers on January 23, 2020.

Providers wishing to download their 2019 1099 from www.ctdssmap.com would do so by logging into their secure Web portal account, selecting Trade Files then download. Providers must then click on the 1099s selection located at the top of the drop-down menu.

As a courtesy, the 2018 1099s will also be loaded to providers' secure Web portal accounts in the middle of February 2020 for historical reference.

Reminders:

Inpatient Admit Change from Medical to Psychiatric

When a HUSKY client is admitted and the primary reason for the admission is medical in nature, the hospital should request a medical Prior Authorization (PA) from Community Health Network of Connecticut (CHNCT) to process the authorization through discharge. If the client is subsequently transferred to a psychiatric unit, the hospital should administratively discharge (Patient Status 65) the client from medical and re-admit the client to behavioral health (Admit Source D) to qualify for the per diem rate for the behavioral health portion of the stay. Upon re-admission to behavioral health, the hospital should request a per diem PA from Connecticut Behavioral Health Partnership (CT BHP) to process the authorization through discharge. In this case, the hospital must submit two separate inpatient claims, with two different admit dates.

Inpatient Admit Change from Psychiatric to Medical

When a HUSKY client is admitted and the primary reason for the admission is behavioral health, the hospital should request a PA from CT BHP to process the authorization through discharge. If the primary focus of treatment shifts to medical and the client is subsequently transferred to a medical bed, the hospital should administratively discharge the client from behavioral health and re-admit (Admit Source D) the client to medical service. Upon readmission, the hospital should request a PA from CHNCT to process the authorization through discharge to be reimbursed via DRG payment methodology for the medical portion of the stay. In this case, the hospital must submit two separate inpatient claims, with two different admit dates.

Inpatient Admit Change to Rehabilitation Services

If a HUSKY Health Program client, who received a behavioral health authorization or medical authorization upon admission, requires further inpatient rehabilitation care, the hospital should administratively discharge (Patient Status 62) the client from behavioral health or medical and re-admit (Admit Source D) the client for rehabilitation services to qualify for further payment. A per diem PA for acute rehabilitation per diem services should be requested from CHNCT.

Refer to Provider Bulletin 2015-22 Inpatient Hospital Modernization - Per Diem Payments for Rehabilitation and Behavioral Health for additional information.

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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.

Provider Manual Chapter 12

Provider manual chapter 12 provides a detailed description of the cause of key Explanation of Benefits (EOB) codes and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition. This guide also provides tips by identifying where providers can go to find additional information to assist with correcting their claims.

DRG and APC specific EOB codes are in provider manual chapter 12.

EOB Code 0671 - DRG covered/non-covered days disagree with the statement period

Cause: The covered days (value code 80) plus non-covered days (value code 81) does not equal the number of elapsed days based on the admission date and header through date of service. Add 1 to the service days if the patient status is 30 (still a patient).

Resolution: Review the admission date, header through date of service, covered and non-covered days, and patient discharge status to determine which field is in error, correct and resubmit the claim.

EOB code 0337 - "APC – Total Allowed Amount on APC Claim is Zero."

Cause: The outpatient claim was billed with an APC payable procedure code that was denied with a different EOB code causing there to be no APC payable allowed amount on the claim.

Resolution: Please review the other EOB code setting on the APC payable procedure code and, once you resolve that EOB, it should resolve EOB 0337 at the same time.

Example: Outpatient claim denies with EOB 0337, but one of the details is also denying with EOB 0856 "Required Operating Provider Number is Missing". If the hospital adds the operating provider number to the claim and re-submits the claim, the claim could process without denying for EOB 0337.

TPL Audit Report – March 2020

The Third-Party Liability (TPL) Audit reports were sent to the following hospitals on March 3, 2020: Greenwich Hospital, St. Francis Hospital and SVMC Holdings.

Re-enrollment Reminder for Hospitals

The hospitals are reminded to take note of their re-enrollment due date with CMAP. Failure to complete and submit their re-enrollment application in enough time to allow for review by DSS by the re-enrollment due date will cause the hospital to be dis-enrolled on the re-enrollment due date and no claims after that date will be allowed until the re-enrollment is completed.

This will impact claims processing and the hospitals' ability to verify eligibility until the re-enrollment has been completed.

The following hospitals have re-enrollment due dates coming up in the near future:

- Yale New Haven Hospital – Outpatient Dental Clinic – 04/07/2020

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- The Hospital of Central Connecticut – Outpatient Hospital – 05/01/2020

HOLIDAY CLOSURE

Please be advised, DSS and DXC Technology will be closed on Friday, April 10, 2020 in observance of the Good Friday Holiday. DSS and DXC Technology will re-open on Monday, April 13, 2020.