interChange Provider Important Message

Hospital Monthly Important Message Updated as of 05/12/2020

*all red text is new for 05/12/2020

CMAP Addendum B April 2020

The Department of Social Services (DSS) updated 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 April 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 April 2, 2020 with an April 1, 2020 effective date for dates of service April 1, 2020 and forward. DXC Technology has determined there were no outpatient claims that processed with the incorrect payment for dates of services April 1, 2020 and forward.

Any other procedure code adds, changes or deletes with an effective date of April 1, 2020 and forward were updated on April 22, 2020. Any outpatient claims processed between April 1, 2020 and April 21, 2020 with APC weight changes and status indicator changes or "New" procedure on the CMAP Addendum B will be adjusted in a future claim cycle and the important message will be updated at that time.

DSS updated procedure codes 87635, U0001 and U0002 to be effective for date of services March 13, 2020 and forward on April 29, 2020. Any outpatient claims submitted prior to April 29, 2020 that billed with those procedure codes can be adjusted by the hospital and any details with procedure codes 87635, U0001 and U0002 that previously denied will be processed.

3M Grouper (DRG Inpatient Admissions)

The update to the ICD-10 (International Statistical Classification of Diseases) related to the new COVID-19 diagnosis code effective April 1, 2020 caused inpatient Diagnostic Related Group (DRG) claims with header Through Date of Service (TDOS) April 1, 2020 and forward to suspend with either Explanation of Benefit (EOB) code 0693 "Invalid Principal Diagnosis" or EOB code 0920 "3M Grouper Error" until the new 3M Grouper was updated on April 22, 2020. Any inpatient claims in a suspended status were released in the April 24, 2020 claims cycle and appeared on the April 28, 2020 Remittance Advice.

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 are reminded the provider assistance center does not verify client eligibility for current dates of service. Hospitals need to log into their secure Web portal account at www.ctdssmap.com in order to verify a client's eligibility. Hospitals are reminded that the self-service functions including Client Eligibility, Web Claim Submission, Claims Status Inquiry, Paid Claim Adjustments, Pharmacy Prior Authorization Request Submissions and Prior Authorization status requests are available to providers through their secure Web portal account.

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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Hospital Refresher Workshops:

HPE MyRoom Virtual Classroom Training
Thursday May 21, 2020 1:00 PM – 4:00 PM

HPE MyRoom Virtual Classroom Training
Wednesday May 27, 2020 9:00 AM – 12:00 PM

The topics include:

- Telemedicine and Audio-Only (Telephonic) Services
- Prior Authorization
- Web Claim Submission
- CMAP Addendum B
- APR DRG Processing
- Frequent Claim Denial
- Resources and Questions

To register for these workshops, visit the www.ctdssmap.com Web site, go to the Hospital Modernization page and click on the Provider Training link in the quick link box. Under workshops, click on the Hospital Refresher Workshop Invitation. Click on the registration link for the workshop you wish to attend and fill out the corresponding information.

Provider Bulletins

Provider Bulletin 2020-45 CMAP COVID-19 Response - Bulletin 29: Updated Guidance Regarding Audio-Only Telephone Services and Guidance Regarding the Use of Synchronized Telemedicine Services for Supervision of Resident Services

Effective for dates of service on and after March 18, 2020 until the Department of Social Services (DSS) has notified providers in writing that the state has deemed COVID-19 no longer to be a public health emergency (the "Temporary Effective Period"), DSS is (1) expanding coverage of audio-only telephone services to new patients and (2) providing guidance related to the supervision of residents through the use of synchronized telemedicine under the Connecticut Medical Assistance Program (CMAP).

Provider Bulletin 2020-44 CMAP COVID-19 Response - Bulletin 30: Updated Audio-Only Behavioral Health (Telephonic) Services - NEW Billing Guidance

The following procedure codes previously used for BH services rendered via telephone (audio-only) will be end-dated effective May 6, 2020; 98967 and 98968.

Effective for dates of service (DOS) on or after May 7, 2020, until the state deems COVID-19 to no longer be a public health emergency (the Temporary Effective Period) BH procedure codes can be used to bill BH services for both new and established patients. The identified modifier CR "Catastrophe Related Claims" must be submitted on the claim to signify that the services are rendered via audio-only (telephone). The hospitals need to continue to follow the guidelines published by DSS related to the provision of telemedicine and telephonic services.

All of these services will be paid at the same rate as the equivalent in-person services when rendered as an audio-only service.

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Provider Bulletin 2020-43 CMAP COVID-19 Response - Bulletin 27: Emergency Medicaid for Non-Citizens

DSS has determined that assessment of COVID-19 (coronavirus), including testing and testing-related services, as well as hospital treatment of COVID-19 constitute "emergency medical conditions" that will qualify for coverage under emergency Medicaid. DSS bases this interpretation on a number of factors, including, but not limited to, the current uncertainty surrounding the clinical severity and risk of mortality for any given individual who may have been exposed to the virus.

Hospitals should continue to follow the current process for submission of claims for emergency medical conditions, hospitals can refer to provider bulletin 2019-34 "Expedited Medicaid Eligibility Processing for Individuals with Medical Emergencies" for additional guidance.

Provider Bulletin 2020-42 CMAP COVID-19 Response - Bulletin 27: New COVID-19 Coverage Group for Uninsured Residents

Effective March 18, 2020, a new federal law, the Families First Coronavirus Response Act (FFCRA), created a new, optional eligibility category for states to expand Medicaid coverage to certain individuals for coverage of COVID-19 testing and testing-related services. To qualify for this eligibility group, potential beneficiaries must meet the definition of an "uninsured individual" as defined by FFCRA.

DSS will be issuing more detailed guidance on this new coverage group in the near future.

In the interim, all Connecticut residents who are seeking COVID-19 testing should be encouraged to apply for full medical coverage through Access Health CT at www.accesshealthct.com or by calling 1-855-805-4325. Enrollment in the new coverage group may be done retroactively, with effective dates on and after March 18, 2020.

Finally, DSS would like to remind hospitals, health systems and hospital-based facilities of the requirements of Executive Order 7U (available at https://portal.ct.gov//media/Office-of-the-Governor/ExecutiveOrders/Lamont-Executive-Orders/ExecutiveOrder-No-7U.pdf), including, but not limited to, the sections that state:

No hospital shall bill any individual not otherwise covered by any public or private health plan for services received for treatment and management of COVID-19, unless and until clarified by further executive order regarding distribution of any federal funding that may be made available to cover such services.

Provider Bulletin 2020-38 CMAP COVID-19 Response - Bulletin 26: Additional Changes to the Synchronized Telemedicine Program

Refer to Table A for an Approved Emergency Telemedicine Procedure Codes list.

Hospitals should refer to CMAP Addendum B to verify which services are covered to be performed as telemedicine. If the service is on Table A but is not covered under CMAP Addendum B the services is not payable for hospitals.

Provider Bulletin 2020-33 CMAP COVID-19 Response - Bulletin 23: Changes to the Prior Authorization Requirement for Specified Services

As an interim measure in response to the Governor's recent declaration of a public health emergency as the result of the outbreak of COVID-19 (coronavirus), the Department of Social Services (DSS) is temporarily changing the prior authorization (PA) requirements for specified services effective for

dates of service April 1, 2020 until DSS has notified providers in writing that the state has deemed COVID-19 to no longer to be a public health emergency (the "Temporary Effective Period").

During the Temporary Effective Period, all in-state and border hospital admissions will not require PA. This applies to all inpatient general acute care hospitals, children's hospitals, chronic disease hospitals and freestanding psychiatric hospitals. Please note that Out-of-State inpatient hospital admissions continue to require prior authorization from the applicable administrative service organization.

All inpatient behavioral health and rehabilitation services continue to remain an all-inclusive payment to the hospital; therefore, professional services cannot be billed separately. Any inpatient admission that is either billed with Revenue Center Code (RCC) 124 or 126 and/or assigned a DRG of 740-776 (behavioral health) will pay at the hospital's behavioral health per-diem rate.

Any inpatient admission billed with Revenue Center Code (RCC) 128 and/or assigned a DRG 860 (rehabilitation) will be paid at the hospital's Rehab per diem rate.

For a list of outpatient behavioral health services and radiology and imaging services that have the prior authorization requirements waived please refer to the provider bulletin.

Provider Bulletin 2020-09 New Coverage of Specified Telemedicine Services Under the Connecticut Medical Assistance Program (CMAP)

Provider Bulletin 2020-10 CMAP COVID-19 Response - Bulletin 1: Emergency Temporary Telemedicine Coverage

Provider Bulletin 2020-14 CMAP COVID-19 Response - Bulletin 4: Expanded Telemedicine and New Audio-Only (Telephonic) Services

Effective for dates of service March 13, 2020 and forward, in accordance with section 17b245e of the 2020 supplement to the Connecticut General Statutes, the Department of Social Services (DSS or Department) will implement full coverage of specified synchronized telemedicine, which is defined as an audio and video telecommunication system with real-time communication between the patient and practitioner.

The hospital can bill for the following behavioral health services for establish patients performed as telemedicine services as an all-inclusive outpatient claim following current billing instruction from CMAP Addendum B for procedure codes 90832-90834, 90836-90838 and 90847.

Effective for dates of service March 18, 2020 and forward the hospitals can bill these services if they are done telephonically (audio-only). If they are done via the telephone, the hospitals would need to bill with Revenue Center code (RCC) 914 and either procedure code 98967 (11-20 minutes) or 98968 (21-30 minutes). If the telephone call exceeds 41 minutes the hospital can bill both CPT codes on the same date of service.

Psychiatric Diagnostic Evaluations (procedure code 90791 or 90792) can only be done through telemedicine only.

The hospital should not be billing for Evaluation and Management (E&M) Services Rendered to Established Patients via the Telephone. These services are not listed on CMAP Addendum B as a covered service and should be billed under the physician/physician group provider ID.

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Provider Bulletin 2020-23 CMAP COVID-19 Response – Bulletin 8: Emergency Temporary Telemedicine Coverage for Physical Therapy, Occupational Therapy & Speech Therapy Services

Effective for dates of service from 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 "Temporary Effective Period"), specified physical therapy (PT), occupational therapy (OT) and speech & language pathology (SLP) services will be permissible to be rendered to established patients only when rendered via synchronized telemedicine, which is defined as real time live audio and video technology, in accordance with the provisions below.

Outpatient hospitals must continue to follow CMAP Addendum B regarding reimbursement for PT, OT and SLP services. The following Revenue Center Codes (RCCs) are approved for telemedicine and must continue to be billed by the hospital when PT, OT or SLP services are rendered via telemedicine:

RCC 421 - PT visit, RCC 431 - OT visit and RCC 441 - SLP visit

PT, OT and SLP services are paid as an all-inclusive rate to the hospital and professional services cannot be billed separately. Prior Authorization guidelines still apply to PT, OT and SLP services.

Provider Bulletin 2020-25 CMAP COVID-19 Response – Bulletin 10: Expanded Use of Synchronized Telemedicine for Specified Behavioral Health Group Therapy Services and Autism Spectrum Disorder Services

Effective for dates of service from March 23, 2020 until DSS has notified providers in writing that the state has deemed COVID-19 no longer to be a public health emergency (the "Temporary Effective Period"), BH group therapy and ASD services will be permissible to be rendered via synchronized telemedicine, which is defined as an audio and video telecommunication system with real-time communication between the patient and practitioner. These services cannot be rendered using audio-only (telephone).

Outpatient hospitals must continue to follow the Connecticut Medical Assistance Program (CMAP) Addendum B regarding reimbursement for outpatient hospital behavioral health (BH) services. All BH services rendered in the outpatient hospital must continue to be billed by the hospital.

Frequently Asked Questions (FAQs) About CMAP's Response to COVID-19 (Coronavirus)

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

HOLIDAY CLOSURE

Please be advised that DSS and DXC Technology will be closed on Monday, May 25, 2020 in observance of the Memorial Day holiday. Both DSS and DXC Technology offices will re-open on Tuesday, May 26, 2020.