interChange Provider Important Message

Hospital Monthly Important Message Updated as of 06/09/2020

*all red text is new for 06/09/2020

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 were adjusted in the May 22, 2020 claim cycle and appear on your May 27, 2020 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with a region code 55.

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.

All Patient Refined – Diagnosis Related Group (APR-DRG)

Effective for discharges on or after January 1, 2020, the adjustment factor added to the All Patient Refined – Diagnosis Related Group (APR-DRG) base payment calculation under State Plan Amendment (SPA) 19-0011 was updated, as clarified under SPA 20-0001. The DRG calculator and system was updated to reflect those changes on May 28, 2020.

DXC has tentatively scheduled a special cycle for June 12, 2020 to reprocess inpatient claims using the corrected adjustment factors and the claims will appear on your remittance advice dated June 16, 2020. The interim payments issued on March 31, 2020 for the estimated difference between the factors for January through March will be recouped at that time as well.

Inpatient Hospital Providers: Behavioral Health Inpatient Authorizations

During the Temporary Effective Period, as stated in PB 20-33 CAMP COVID-19 Response – Bulletin 23: Changes to the Prior Authorization Requirements for Specified Services all in-state and border hospital admissions will not require PA.

However. any hospital that has requested and received an inpatient behavioral health authorization from Beacon Health Options for admissions after April 1, 2020 must continue to have the authorization updated with Beacon Health Options for the entire admission.

If the hospital submitted their inpatient claims and received Explanation of Benefits (EOB) code 3000 "Prior Authorization Services are Cutback or Exhausted" on their claim, or the hospital only received partial payment for the inpatient stay, please do not contact DXC Provider Assistance Center or Beacon Health Options to make updates to the authorization.

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DXC Technology is working with Beacon Health Options to update the current authorization(s) on file. Once corrected the important message will be updated and the hospitals will be able to adjust their inpatient claims for processing.

If the hospitals have not submitted any inpatient claims for a specific inpatient authorization, they should continue to work with Beacon Health Options to update the authorization for the entire admission. Please verify your authorization on the www.ctdssmap.com Web site under the provider's secure site prior to submitting your inpatient behavioral health claims.

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.

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. Hospital 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 Bulletins

Provider Bulletin 2020-51 - Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)

The Department of Social Services (DSS) and DXC Technology have published the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and 835 schedules for July 2020 to December 2020.

Provider Bulletin 2020-50 CMAP COVID-19 Response - Bulletin 36: Wheelchair Assessments Rendered Via Synchronized Telemedicine by Physical and Occupational Therapists

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 (1) adding procedure code 97542 – wheelchair management (e.g., assessment, fitting, training) each 15 min to the list of eligible codes to be rendered via synchronized telemedicine (live audio and video) and (2) providing billing guidance for wheelchair assessments rendered via synchronized telemedicine.

Effective for dates of service retroactive to April 1, 2020 until DSS has notified providers in writing that the state has deemed COVID19 no longer to be a public health emergency (the "Temporary Effective Period"), physical therapist (PTs) and occupational therapists (OTs) can render wheelchair assessments via synchronized telemedicine.

Outpatient hospitals must continue to follow CMAP Addendum B regarding reimbursement for PT and OT services.

Provider Bulletin 2020-48 CMAP COVID-19 Response - Bulletin 32: Services Covered under the Optional Medicaid Coverage Group "COVID-19 Testing Group" for Uninsured Connecticut Residents

The Department of Social Services (DSS) implemented an optional Medicaid coverage group, "COVID-19 Testing Group" for uninsured Connecticut residents effective March 18, 2020. This optional eligibility group provides coverage for the testing for COVID-19 and the office visit related to testing for COVID-19. Please refer to PB 2020-42 CMAP COVID-19 Response – Bulletin 27: New COVID-19 Coverage Group for Uninsured Residents, for additional details regarding eligibility under this optional group.

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The DXC Automated Eligibility Verification System (AEVS) will return client information that identifies if a client is eligible for the new optional Medicaid coverage group, "COVID19 Testing Group". This is a limited benefit coverage group for Connecticut residents who are citizens or qualified non-citizens who do not otherwise qualify for Medicaid or who do not have coverage through Medicare, or any other health plan or program.

The eligibility verification response for this population will be **"COVID-19 Limited Coverage".** Effective for dates of service between March 18, 2020 and the end of the federally declared public health emergency, the procedure code listed in the provider bulletin are covered under the COVID-19 Testing Group.

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 13, 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.

Provider Bulletin 2020-43 CMAP COVID-19 Response – Bulletin 28: 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 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.

Provider Manual Chapter 12 – Claim Resolution Guide

Provider manual chapter 12 provides a detailed description of the cause of each Explanation of Benefits (EOB) and more importantly the necessary directions to resolve the error. This guide also provides where hospital can go to find additional information to assist with correcting their claims.

Explanation of Benefits (EOB) codes 314 "APC - Observation revenue code on line item with non-observation HCPCS code" and EOB code 5077 "Inpatient stay denied due to a paid outpatient claim within 3 days prior to inpatient admission" were updated on June 4, 2020.