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Hospital Monthly Important Message Updated as of 07/01/2020

*all red text is new for 07/01/2020

CMAP Addendum B July 2020

The Department of Social Services (DSS) will be updating the Connecticut Medical Assistance Program (CMAP) Addendum B for dates of service July 1, 2020 and forward in July. The payment rate changes for procedure codes assigned a status indicator G or K will be updated and loaded into the system prior to July 1, 2020. Any claims that are submitted for dates of service July 1, 2020 and forward that have a status indicator of G or K will process at the correct payment rate.

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.

In a special cycle on June 12, 2020 DXC Technology reprocessed inpatient claims using the corrected adjustment factors and the claims appeared 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 from this payment. The recoupments did not appear on the Remittance Advice for the special cycle but posted as Accounts Receivable to the hospital's June 23, 2020 Remittance Advice for the regularly scheduled financial cycle. This amount appears as a balance due, but it was already taken from the EFT payment on June 16, 2020 and will be removed from the hospital's next remittance advice.

Provider Bulletin 2020-54 - CMAP COVID-19 Response - Bulletin 38: Increase in Inpatient Hospital Reimbursement for COVID-19 Claims Paid under the All Patient Refined-Diagnosis Related Group (APR-DRG) Methodology

This policy transmittal was to inform providers that, effective for discharges from April 1, 2020 through June 30, 2020, the base payment made under the APR-DRG methodology for a Medicaid patient diagnosed with COVID-19 will be increased by 20%. The hospital must report the COVID-19 diagnosis code U07.1 on the claim to receive the increased payment.

As of July 1, 2020, the system was updated to process inpatient medical stays with the COVID-19 diagnosis to receive the increased payment for discharges April 1, 2020 through June 30, 2020.

The DRG calculator was updated on the www.ctdssmap.com Web site under hospital modernization page to calculate the inpatient claims that report the COVID-19 diagnosis on their claims.

All such inpatient claims submitted and paid prior to the issuance of this bulletin will be identified and reprocessed by DXC Technology in a special cycle tentatively scheduled for July 17, 2020.

Inpatient Hospital Providers: Behavioral Health Inpatient Authorizations Update

During the Temporary Effective Period, as stated in PB 2020-33 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.

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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.

Beacon Health Options has updated the current authorization(s) on file. The hospitals can adjust their behavioral health inpatient claims.

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.

Inpatient behavioral health payment is 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, and 817 will pay at the hospital's behavioral health per-diem rate.

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 2020-49 - CMAP COVID-19 Response - Bulletin 33: Addition of Laboratory Procedure Codes to Various Fee Schedules and Updating the Effective Date on Procedure Code U0001 and U0002 Previously Added to the Consolidated Laboratory Fee Schedule

Procedure codes U0001 and U0002 were previously added to the Connecticut Medical Assistance Program's (CMAP's) Laboratory fee schedule and CMAP's Addendum B with an effective date of March 18, 2020. DSS updated the effective date from March 18, 2020 retroactively to March 13, 2020.

All other information listed in PB 2020-12 CMAP COVID-19 Response – Bulletin 2: Laboratory Testing Coverage remains effective except the effective date has been changed as noted above. Outpatient Hospitals must continue to follow CMAP Addendum B for coverage and payment of all outpatient hospital services

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Provider Bulletin 2020-37 - CMAP COVID-19 Response – Bulletin 24: Addition of Laboratory Procedure Codes to the Independent Laboratory Fee Schedule

Effective for dates of service April 14, 2020 and forward, procedure code U0003 should be billed to identify tests that would otherwise be identified by procedure code 87635 but being performed with high throughput technologies. Procedure code U0004 should be billed to identify tests that would otherwise be identified by U0002 but being performed with high throughput technologies. It is noted that neither U0003 nor U0004 should be used for tests that detect COVID-19 antibodies.

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.
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.

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.

Diagnostic Related Group (DRG) Coding Reviews

For assistance with DRG coding reviews the hospitals can contact Health Management Systems, Inc. (HMS) provider relations at 1-866-206-6855 or via email to PIStatusrequest@hms.com.

HMS will provide an online provider portal to streamline the review process, facilitate communication, and offer claims status information to stakeholders throughout the review cycle. Training and support information will be offered to hospital staff.

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Inpatient Hospital Fee Schedule for Organ Acquisition Costs

The table below contains historical and current Organ Acquisition rates for both in-state and out-of-state hospitals for Revenue Center Code (RCC) 810, 811 and 812.

Organ	Flat Fee	Effective date	End date
Kidney	$79,300	7/1/2020	12/31/2299
Heart	$113,634	7/1/2020	12/31/2299
Liver	$135,022	7/1/2020	12/31/2299
Pancreas	See Below	7/1/2018	12/31/2299
Lung	See Below	1/1/2015	12/31/2299

Payment will be the lower of charges or state-wide average.
*For lung or pancreas acquisition, the hospital must submit their most recent Medicare cost report submitted to CMS to DSS.

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.

HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) and DXC Technology will be closed on Friday, July 3, 2020 in observance of the Independence Day holiday. Both the DSS and DXC Technology offices will re-open on Monday, July 6, 2020.