interChange Provider Important Message

Hospital Monthly Important Message Updated as of 08/11/2020

*all red text is new for 08/11/2020

CMAP Addendum B July 2020

The Department of Social Services (DSS) updated the Connecticut Medical Assistance Program (CMAP) Addendum B for dates of service July 1, 2020 and forward on July 28, 2020. 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.

Any procedure code that is "NEW", changed or deleted with an effective date of July 1, 2020 was updated on July 28, 2020. Any claims with new or changed procedure codes are tentatively scheduled to be adjusted in the 2nd claim cycle in September.

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 were identified and reprocessed by DXC Technology in the July 17, 2020 special claim cycle and the claims appeared on your Remittance Advice dated July 21, 2020.

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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.

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.

W-416 Newborn Forms

The hospital can use the following email address to inquire about the status of the W416 newborn forms: ExpeditedHusky.DSS@ct.gov.

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 (CMAP) Laboratory fee schedule and CMAP Addendum B with an effective date of March 18, 2020. DSS retroactively updated the effective date from March 18, 2020 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

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.

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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.

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.

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 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.