interChange Provider Important Message

Hospital Monthly Important Message Updated as of 09/04/2020

*all red text is new for 09/04/2020

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.

DXC Reprocessing

DXC Technology identified and reprocessed inpatient DRG claims that processed at the incorrect DRG weight. These claims will appear on the September 9, 2020 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 55.

Provider Bulletins

Provider Bulletin 2020-63 - Removal of Prior Authorization for Procedure Codes 81420 and 81507

Effective for dates of service September 1, 2020 and forward, the Department of Social Services (DSS) is removing Prior Authorization (PA) requirements for procedure code 81420 "Fetal chrmoml aneuploidy" and procedure code 81507 "Fetal aneuploidy trisom risk; therefore, any pregnant HUSKY Health member, regardless of pregnancy risk category, is eligible to receive these services as long as the services are deemed medically necessary by their provider. Please refer to the Connecticut Medical Assistance Program's definition of medical necessity as defined in Conn. Gen. Stat. Section 17b-259b or in PB 11-36 – Definition of Medical Necessity.

Provider Bulletin 2020-59 - Removal of Prior Authorization for Procedure Codes 81528 and 81511

Effective for dates of service August 1, 2020 and forward, the Department of Social Services (DSS) is removing Prior Authorization (PA) requirements for procedure code 81528 "Oncology (colorectal) screening (Cologuard)" and procedure code 81511 "Fetal congenital abnormalities, biochemical assays of four analytes."

Hospital must continue to refer to the Independent Laboratory fee schedule for PA requirements.

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.

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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.

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

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.

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.

Any inpatient admission billed with Revenue Center Code (RCC) 128 and/or assigned a DRG 860 (rehabilitation) or 862 (Other Aftercare & Convalescence) will be paid the hospital's Rehab per diem rate.

Reminders:

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 Manual Chapter 12 – Claim Resolution Guide

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

Explanation of Benefit (EOB) Code 4127 - Benefit Plan Hierarchy is not Found, Contact the Provider Assistance Center

Cause - The client's eligibility changed during the inpatient or outpatient crossover claim and is requiring the claim to be split into two claims, so it doesn't overlap the change.

Resolution - Perform a client eligibility verification transaction to determine the client's eligibility during the stay and split the claim accordingly. If the hospital cannot determine how to split the claim, the hospital may contact the Provider Assistance Center (PAC) for assistance.

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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. Hospitals 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 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.