interChange Provider Important Message

Hospital Monthly Important Message Updated as of 10/8/2021

*all red text is new for 10/8/2021

CMAP Addendum B October 2021

DSS and Gainwell Technologies are reviewing the October version of CMAP Addendum B. Provider notification will be distributed when that has been updated and posted to the Hospital Modernization page on the www.ctdssmap.com Web site.

The payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system prior to October 1, 2021. Any claims that are submitted for dates of service October 1, 2021 and forward that have a status indicator of G or K will process at the correct payment rate.

Annual Rates/Parameters for the Outpatient Payment Prospective System (OPPS)

Providers are reminded that they will receive their annual rates/parameters letter for the Outpatient Payment Prospective System (OPPS) in December.

Annual 3M Grouper Updates

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Updates

The update to the ICD-10 (International Statistical Classification of Diseases) codes effective October 1, 2021 may cause inpatient Diagnostic Related Group (DRG) claims with header Through Date of Service (TDOS) October 1, 2021 and forward to suspend with either EOB code 0693 "Invalid Principal Diagnosis" or EOB code 0920 "3M Grouper Error" until the new 3M Grouper is loaded. Once the updated grouper version is loaded into the system the claims will be re-cycled for processing. An important message will be posted once the new grouper version has been scheduled to be loaded into the system.

Diagnosis Related Grouper (DRG) October Updates

For the October 1, 2021 update, there were no new or deleted DRGs.

Diagnosis Related Grouper (DRG) January Updates - DRG Weight, Average Length of Stay (ALOS) and Outlier Threshold

Per the amendment to Attachment 4.19-A of the Medicaid State Plan, DSS shall pay for hospital inpatient services on a fully prospective per discharge basis using DRG-based payments. Diagnosis related groups will be assigned using the most recent version of the 3M All Patient Refined Diagnosis-Related Grouper (APR-DRG) with each new grouper version released by 3M being implemented the subsequent January 1st. DRG Weights, average length of stays and outlier thresholds for the new version will all have an effective date of January 1, 2022.

A provider bulletin will be distributed in December 2021 reminding hospitals of the annual update to the inpatient hospital adjustment factors and the APR-DRG weights, effective January 1, 2022. Once the DRG calculator has been updated and posted to the www.ctdssmap.com Web portal with that most current information, additional provider notification will be distributed.

interChange Provider Important Message

Provider Bulletins

Note that the following reflects an overview of provider bulletins distributed since the last Hospital Monthly Important Message was posted. Hospitals should use the links presented below to review the full bulletin.

Provider Bulletin 2021-64 - Diagnostic Related Group (DRG) Review Process

The Department of Social Services (DSS) has been conducting reviews of inpatient hospital claims paid under the Diagnostic Related Group (DRG) methodology to ensure DSS is reimbursing the proper amount for these claims in conformance with Connecticut Medical Assistance Program (CMAP) policy. These post payment reviews are conducted by DSS' contractor, Health Management Systems, Inc. (HMS). Based on DRG review feedback from CT hospitals, DSS has implemented a new procedure which will reprice claims finalized through the DRG process directly in the Medicaid Management Information System (MMIS). This replaces the recoupment and rebill process and will expedite the issuance of final payment. Please refer to the CT DSS DRG Provider Review Process documented below for an outline of the overall process, what to expect at each stage, and important contact information.

Please refer to the provider bulletin for additional information. Note that the change (to not fully recoup inpatient claims) began on June 1, 2021. Otherwise, the process remains the same as it has always been. Any questions on that process can be directed to HMS.

Provider Bulletin 2021-65 - Medicaid Coverage of Chiropractic Services

In accordance with recently enacted state law in section 331 of Public Act 21-2 of the June 2021 Special Session, effective for dates of service October 1, 2021 and forward, chiropractic services will be reinstated as a covered service under the Connecticut Medical Assistance Program (CMAP) for HUSKY Health members.

Please refer to the provider bulletin for additional information.

Provider Bulletin 2021-70 - New Medicaid Coverage of Services Provided by Licensed Acupuncturists in Independent Practice

In accordance with recently enacted state law in section 331 of Public Act 21-2 of the June 2021 Special Session, effective for dates of service October 1, 2021 and forward, the Department of Social Services (DSS) will cover services rendered by independent acupuncturists in the office setting in Connecticut's Medicaid program. To be eligible for reimbursement under Medicaid, the acupuncturist must be licensed by the State of Connecticut Department of Public Health (DPH) and enroll as an independent acupuncturist with HUSKY Health. Acupuncture services will be covered for all members under HUSKY A, C, and D. Services provided by acupuncturists in independent practice continue to be non-covered under HUSKY B.

Please refer to the provider bulletin for additional information, including information on enrollment criteria and fee schedules.

Provider Bulletin 2021-73 - Other Insurance/Medicare Claim Submission Instruction Reminders

The Connecticut Medical Assistance Program (CMAP) is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance coverage or Medicare, the benefits of these policies must be fully exhausted prior to claim submission to the CMAP. Chapter 11 of the Provider Manual contains important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment or denied a claim.

interChange Provider Important Message

Chapter 11 can be accessed from the www.ctdssmap.com Web site by selecting Information > Publications, and then selecting the appropriate claim type from the drop down box.

Please refer to the provider bulletin for additional information on how to identify Connecticut specific third party insurance carriers, how to submit that data on claims, and other useful resources. Also note that the carrier code lists posted at www.ctdssmap.com are now posted as Excel spreadsheets for providers to easily download to their systems, if desired. These lists are updated the first business day of each month.

Provider Bulletin 2021-74 - Outpatient Crossover Claim Pricing Changes

Outpatient Providers – Outpatient Crossover Claims Only

Effective for dates of service on and after September 1, 2021, claims that crossover directly from Medicare or that are submitted by an outpatient hospital provider with Medicare information at the claim detail will now be priced using the information that is submitted at the detail level.

Additionally, outpatient hospital providers submitting Medicare information at the claim detail can now submit copay information, using claim adjustment reason code (CARC) of 3.

No claim submission changes are currently required for any outpatient hospital provider that may not be submitting Medicare information at the detail level. However, that will be required in the future. Chapter 11 of the Provider Manual, available via the www.ctdssmap.com Web site by selecting Information > Publications and selecting the appropriate claim type from the drop down box, outlines the ASC X12N 837I loops and segments needed to submit the Medicare information at the detail level. Trading partners/providers are encouraged to begin to make necessary changes to support the above requirements now. Additional provider notification will be distributed with implementation timeframes and instructions on how to submit the required claim detail information.

Additionally, changes will be made to the Web claims submission panels available via a provider's Secure Web portal account when logged on via www.ctdssmap.com to allow providers to submit Medicare information at the claim detail. Providers will be notified when those changes are available. Adequate time will be allotted for providers to make the changes required to submit Medicare information at the claim detail. However, upon implementation, if that information is not submitted at the claim detail, providers will experience claim denials.

Please refer to the provider bulletin for additional information, including information and available resources on the appropriate ASC X12N 837 I Health Care Claim loops and segments that should be used.

All hospital providers are strongly encouraged to begin modifying their systems now to submit outpatient Medicare crossover claims at the claim detail level. At a future date to be determined by DSS, any claims not submitted in that format will deny. As a reminder, hospitals should not be billing any outpatient crossover claims under their inpatient hospital specialty.

Provider Bulletin 2021-75 - Revision of Rates for Certain Clinical Diagnostic Laboratory Testing Codes

Effective for dates of service listed below until the Department of Social Services (DSS) declares COVID-19 to no longer be a public health emergency, the reimbursement for the following clinical diagnostic laboratory services is being updated retroactive to the dates as listed below to 100% of the Medicare rate: (reference bulletin for detailed list).

Effective for dates of service March 13, 2020 and forward, DSS is revising the reimbursement for the following procedure code on the Lab Fee Schedule. DSS is implementing this change to comply with

federal Medicaid law (42 U.S.C. § 1396b(i)(7)), which prohibits state Medicaid programs from paying more than Medicare would pay for a laboratory service (reference bulletin for detailed list).

Please refer to the provider bulletin for additional information, including updates to CMAP's Addendum B and fee schedules.

Provider Bulletin 2021-80 - Policy Updates and Changes to Clinical Review Criteria

The purpose of this bulletin is for the Department of Social Services (DSS) to notify enrolled Connecticut Medical Assistance Program (CMAP) providers of upcoming policy updates and changes to clinical review criteria for certain medical services and items.

Please refer to the provider bulletin for new policies and policy updates that are effective November 1, 2021.

TPL Audit Report - October 2021

There were no Third-Party Liability (TPL) Audit reports sent to hospitals on October 1, 2021.

As a reminder, failure to respond to an audit will result in a recoupment of claims. Any claims recouped can be identified by a region code 52 and the Explanation of Benefit (EOB) code 8282 - CLAIM HAS BEEN RECOUPED DUE TO TPL AUDIT FAILURE.

Re-enrollment Reminder for Hospitals

The hospitals are reminded to take note of their re-enrollment due date with CMAP. Failure to complete and submit their re-enrollment application in enough time to allow for review by DSS by **the re-enrollment due date** will cause the hospital to be dis-enrolled on the re-enrollment due date and no claims after that date will be allowed until the re-enrollment is completed.

This will impact claims processing and the hospitals' ability to verify eligibility until the re-enrollment has been completed.

The following hospitals have re-enrollment due dates coming up in the near future:

- Prospect Manchester Hospital, Inc – inpatient and outpatient – 12/13/2021
- Prospect Rockville Hospital, Inc – inpatient and outpatient – 12/14/2021
- Prospect Waterbury, Inc – inpatient and outpatient – 12/14/2021
- St Mary's Hospital – inpatient – 12/28/2021
- Danbury Hospital – inpatient and outpatient – 1/3/2022
- The Hospital of Central Connecticut – inpatient and outpatient - 1/13/2022

Reminders

Limited COVID- 19 Coverage Group

The COVID-19 FAQ document is located on the www.ctdssmap.com Web page on the Home page under Important Messages and is a great resource to use for COVID-19 related questions. Specific to what is covered for the limited coverage group, hospitals should refer to the following bulletins, which can be accessed below or through the FAQ document, for a list of services that are covered under the COVID-

19 Testing Group benefit plan if related to COVID-19 testing. Clients granted coverage for this limited benefit plan are usually not eligible under other HUSKY Health plans.

- PB 2020-42 – CMAP COVID-19 Response – Bulletin 27: New COVID-19 Coverage Group for Uninsured Residents – introduced the new Medicaid coverage group and the eligibility criteria, effective March 18, 2020, for coverage of COVID-19 testing itself and the testing-related provider visit.

- PB 2020-48 – **REVISED** CMAP COVID-19 Response – Bulletin 32: Services Covered under the Optional Medicaid Coverage Group "COVID-19 Testing Group" for Uninsured Connecticut Residents – introduced the services initially covered for this eligibility group – provided detail on the eligibility verification response for this coverage group, the covered services as of March 18, 2020 (i.e. coverage of the test itself, an office visit to determine whether testing is necessary and related services to determine whether testing is necessary, such as a chest x-ray), and the providers eligible to bill for services for this coverage group, which included outpatient hospitals.

- PB 2021-34 - CMAP COVID-19 Response – Bulletin 54: ADDITIONAL Services Covered under the "COVID-19 Testing Group" – updated services for this Medicaid coverage group to services performed to diagnose, treat or vaccinate against COVID-19 infections, effective retroactive to March 11, 2021. At that time, the providers eligible to bill for these services was expanded, including inpatient hospitals, retroactive to March 11, 2021. This bulletin also included a list of diagnosis codes that must be present on claims submitted for this group.

Discontinuation of Internet Explorer Support

Gainwell Technologies is pleased to announce that in the near future, Microsoft Edge and Google Chrome will be the browsers of choice to access the Connecticut Medical Assistance Program Web site at www.ctdssmap.com. Providers are highly encouraged to use either of these tools in place of Internet Explorer, which will no longer be supported. An important message will be posted in the near future with the implementation date of this change.

Provider Assistance Center (PAC) vs. Use of ctxixhosppay@dxc.com

Hospitals should direct most of their inquiries to the 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.

The ctxixhosppay@dxc.com email box should be used to submit APC and DRG related questions, or other non-routine questions.

Hysterectomy Consent Forms, Sterilization Consent Forms or Electronic Claim Attachments

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.

Trauma Questionnaire Responses

Hospitals who wish to submit Trauma Questionnaire Responses may fax them to 1-833-577-3519 or email them to CTXIX-TraumaMailbox@dxc.com.

interChange Provider Important Message

Holiday Closure

Please be advised, the Department of Social Services (DSS) will be closed on Monday, October 11, 2021 in observance of the Columbus Day holiday. DSS will re-open on Tuesday, October 12, 2021. Gainwell Technologies will be open on Monday, October 11, 2021.

gainwell