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Hospital Monthly Important Message Updated as of 12/17/24

*All red text is new for 12/17/24

CMAP Addendum B October 2024

The October version of CMAP Addendum B has been updated and posted to the Hospital Modernization page www.ctdssmap.com Web site. An important message was posted on October 30, 2024 to announce the updates. Attention Outpatient Hospitals: CMAP Addendum B Updated (October 1, 2024)

The Department of Social Services (DSS) and Gainwell Technologies have updated the Connecticut Medical Assistance Program (CMAP) Addendum B to incorporate the 2024 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions, and description changes) for dates of service October 1, 2024 and forward to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

An updated PDF and Excel version of Connecticut Medical Assistance Program (CMAP) Addendum B V25.3 has been posted to the Hospital Modernization page on the www.ctdssmap.com Web site.

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system on September 27, 2024 with an effective date for dates of service October 1, 2024 and forward.

The forthcoming Addendum B changes can be identified by the following indicators:

- "G or K" – A change has been made to the payment rate (status indicator G or K).
- "New" – The procedure code was added by CMS.
- "X" - A change has been made to the procedure code or status indicator.

Older versions of CMAP Addendum B can be found under the Hospital Modernization page under "CMAP Addendum B Changes and Historical Versions."

October ICD-10 Updates

ICD-10 updates for both diagnosis and surgical procedure codes are effective October 1st. There are 371 ICD-10 surgical codes being added and 61 being discontinued and there are 252 diagnosis codes being added and 36 discontinued.

3M Grouper Updates

The new version of the Diagnosis Related Grouper (DRG) has been implemented on October 30, 2024. Claims submitted on 10/30/24 with dates of discharge October 1, 2024 and forward will use the new version of the grouper.

As a result, any claims that were suspended with either Explanation of Benefit (EOB) code 0693 "Invalid Principal Diagnosis" or EOB code 0920 "3M Grouper Error" will be re-cycled for processing and will appear on the hospital's November 13, 2024 Remittance Advice. **Although this was a new version of the grouper, there were no changes to DRG rates or weights.**

Any inpatient claims with a discharge date October 1, 2024 and forward that was processed at the incorrect DRG code will be identified and reprocessed and will appear on the hospital's November 26, 2024 Remittance Advice.

There were also updates made to the DRG Calculator, adding, deleting and updating descriptions to the DRG Codes in the calculator. These changes are effective for dates of service October 1, 2024 and forward.

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Annual 3M Grouper

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 DiagnosisRelated 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, 2025.

A provider bulletin will be distributed in December 2024 reminding hospitals of the annual update to the inpatient hospital adjustment factors and the APR-DRG weights, effective January 1, 2025. Once the DRG calculator has been updated and posted to the www.ctdssmap.com Web site with that most current information, additional provider notification will be distributed.

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

Hospitals are reminded that they will receive their annual rates/parameters letter for the Outpatient Payment Prospective System (OPPS) in December 2024.

Prior Authorization Required for Specific J-codes for Outpatient Hospitals and Outpatient Chronic Disease Hospitals:

Effective for dates of service November 15, 2024, and forward, consistent with current policy or current CMAP requirements, prior authorization (PA) is being added to the following procedure codes for outpatient hospitals and outpatient chronic disease hospitals:

- J0172 Injection aducanumab-avwa 2 mg
- J0174 Injection lecanemab-irmb 1 mg
- J0224 Injection lumasiran 0.5 mg
- J1413 Injection delandistrogene moxeparvovec-rokl
- J1426 Injection casimersen 10 mg
- J1427 Injection viltolarsen 10 mg
- J1429 Injection golodirsen 10 mg
- J3241 Injection teprotumumab-trbw 10 mg
- J7330 Autologous cultured chondrocytes implant

For dates of service November 15, 2024, and forward, failure to obtain PA for the above codes will result in a claim denial.

Providers can access the medical authorization portal and HUSKY Health policies at https://portal.ct.gov/HUSKY.

For questions regarding the prior authorization process, please contact CHNCT at 1-800-440-5071, between the hours of 8:00 a.m. and 6:00 p.m.

Recoupment of Interim Payments Due to Cyber Attack:

DSS has been monitoring claim levels for all providers that received an interim payment due to the Change Healthcare Cyber Attack and has determined that some hospitals are back to normal payment levels based on their claim cycle payments in April and May. Hospitals determined to be back at their normal payment levels will have the full interim payment recouped in the May 24, 2024 claim cycle.

Hospitals will see this in their Remittance Advice (RA) dated May 29, 2024. Hospitals should expect to see the interim payment recouped in full in a future claim cycle, no later than September 30, 2024. You can identity an interim payment recoupment by the reason code 8409 "Provider Interim Payment," under account receivables.

Reimbursement Rate Increases for Select Behavioral Health Services for Children

As of August 13, 2024, DSS increased the reimbursement rates of select behavioral health services (including family therapy services) for HUSKY Health members ages 20 years old and under for dates of service July 1, 2024 and forward.

Claims processed prior to August 13, 2024 where the detailed billed amount is greater than the new allowed amount were retroactively adjusted. Gainwell Technologies has identified and reprocessed these claims on August 27, 2024 and any additional claims were completed and posted to the hospital's remittance advice in the two (2) claim cycles in September 2024, without any additional work on the part of providers.

The fee schedules were updated on 10/21/2024.

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 2024-63

1) **January 1, 2025 Changes to the Connecticut Medicaid Preferred Drug List (PDL)**

The Pharmaceutical & Therapeutics (P&T) Committee has modified the list of preferred prescription products. The Committee has determined these preferred products as efficacious, safe, and cost-effective choices when prescribing for HUSKY A, HUSKY C, HUSKY D, Tuberculosis (TB), Emergency Medicaid Dialysis Service (EMDS), and Family Planning (FAMPL) clients.

2) **Reminder About the 5-day Emergency Supply**

In addition to the one-time 14-day temporary supply, DSS also allows for a 5-day emergency supply of a medication that requires PA for non-PDL or Brand Medically Necessary (BMN). If the pharmacist or prescriber is unable to obtain a PA and the client requires the medication after the one-time 14- day override has been used, the pharmacist may call the Pharmacy Prior Authorization Assistance Call Center, available 24 hours a day, 7 days a week, at 1-866-409-8386 to request a one-time 5-day emergency supply of the medication.

3) **Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)**

This serves to provide clarification on billing requirements for a pharmacy when a brand name medication, which is identified as a preferred product on the Connecticut Medicaid PDL, is dispensed.

4) **Pharmacy Web PA Tool**

Actively enrolled prescribing providers and clerks affiliated to the prescriber can utilize the Pharmacy Web PA feature to:

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Please refer to the provider bulletin for additional information.

Provider Bulletin 2024-65 - Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)

The Department of Social Services (DSS) and Gainwell Technologies are publishing the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and 835 schedule for the benefit of the provider community.

EFTs are generated or checks are mailed to providers who have paid claim activity in the claims processing cycle preceding the mail dates. The ASC X12N 835 Health Care Claim Payment/Advice is in the standard HIPAA Electronic Remittance Advice.

Please refer to the provider bulletin for additional information.

Provider Bulletin 2024-66 - Diagnosis Requirement for GLP-1 Agonist Medications

Effective December 15, 2024, all new prescriptions for GLP-1 agonist medications will require a valid ICD-10 diagnosis code indicating Type 2 diabetes to be submitted in field 424-DO on the NCPDP D.0. pharmacy claim. These medications include Trulicity, Byetta, Bydureon, Rybelsus, Victoza/liraglutide, Ozempic, and Mounjaro (combination GIP and GLP-1).

Please refer to the provider bulletin for additional information.

TPL Audit Report – December 2024

The Third-Party Liability (TPL) Audit reports were sent to the following hospitals on December 1, 2024.

- MOUNT SINAI REHABILITATION HOSPITAL
- NATCHAUG HOSPITAL
- THE DANBURY HOSPTIAL
- VASSAR HEALTH CONNECTICUT, INC

Re-enrollment Reminder for Hospitals

Hospital providers 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.

Dis-enrollment 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 next **6 months**:

- SVMC Holdings, Inc - Psych – 12/27/24
- Norwalk Hospital Association – Outpatient – 1/3/25
- Connecticut Children's Medical Center – Outpatient – 3/26/25

Reminders/Upcoming Changes

Newborn Form W-416 Delays

The typical turnaround time is 24 hours for processing this form. If after 3 business days hospitals do not see the newborn's client ID and are not able to find it on www.ctdssmap.com, hospitals have been instructed to contact the benefit center or email ExpeditedHusky.DSS@ct.gov.

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Authorizations when clients have Medicare or Other Insurance

Hospitals are required to obtain authorization prior to the service being rendered when the client has Other Insurance (OI), and the service requires prior authorization. Prior authorization is not needed when the client has Medicare as their primary insurance and Medicare covers the service. In these situations, the hospital is submitting Medicare's co-insurance and/or deductible to be considered as secondary to Medicaid.

Inpatient Hospital Claims require a Prior Authorization (PA)
Make sure that when you receive two separate per-diem (Rehab or Behavioral Health) PAs, that the PA date ranges do not overlap – when this happens the claim ONLY picks up one of the PAs. A denial could be received for the dates on the second PA**.**

Written Correspondence
For timely filing claims the hospital provider can do one of the following three (3) things:

Submit all claims on paper to Gainwell Technologies by

- FAX: 1-877-413-4241
- EMAIL: **ctdssmap-provideremail@gainwelltechnologies.com**
- MAIL: Written Correspondence - PO Box 2991 – Hartford, CT 06104.

Make sure that a cover letter is attached and that you state the reason why you are sending in the claims on paper.

Claim Denials
If your claim denies please refer to provider manual 12 "**Claim Resolution Guide**". This chapter provides a detailed description of the cause of the Explanation of Benefit (EOB) code and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition. If you need additional assistance, please contact the Provider Assistance Center at 1-800-842-8440 and if PAC is unable to assist, then they will escalate your inquiry.

ctxixhosppay Email Box
As a reminder, hospitals should direct their inquiries to the Provider Assistance Center at 1-800-842-8440. If hospitals are experiencing extended call wait times, hospitals may email the provider assistance call center with their question at ctdssmap-provideremail@gainwelltechnologies.com. Please be sure to include your name and phone number with your inquiry.

The ctxixhosppay@gainwelltechnologies.com email box should only be used to submit **APC and DRG** related questions. **All other inquiries will be re-directed to the Provider Assistance Center at 1-800-842-8440.**

Holiday Closures

Please be advised, that the Department of Social Services (DSS)' and Gainwell Technologies' offices will be closed on Wednesday, December 25, 2024 in observance of the Christmas Day Holiday. The Department of Social Services (DSS) and Gainwell Technologies will re-open on Thursday, December 26, 2024.

Both the Department of Social Services (DSS)' and Gainwell Technologies' offices will be closed on Wednesday, January 1, 2025 in observance of the New Year's Day Holiday. The Department of Social Services (DSS) and Gainwell Technologies will re-open on Thursday, January 2, 2025.
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