interChange Provider Important Message

Hospital Monthly Important Message Updated as of 11/9/2020

*all red text is new for 11/9/2020

DXC Technology Becomes Gainwell Technologies

On October 1, 2020, DXC Technology sold their State and Local Health and Human Services business to Veritas Capital to form a new company, Gainwell Technologies. Hospitals will notice the following changes in the coming weeks:

- Hospitals will begin to see the Gainwell Technologies logo or the Gainwell Technologies name on correspondence.
- Hospitals will begin to receive emails from the @gainwelltechnologies.com email address rather than the @dxc.com email address.
- Hospitals will hear the Gainwell Technologies name when calling the Provider Assistance Center (PAC).

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.

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 have been identified and reprocessed and appeared on your September 22, 2020 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 55.

Outpatient claims billed with Procedure codes 0202U, 0223U, 0224U, or Q5512 will suspend with Explanation of Benefit (EOB) 334 "APC – Blank Status Indicator" until the update to the new grouper is loaded which is tentatively scheduled for November 11, 2020. Once the updated grouper version is loaded into the system the claims will be re-cycled and process based on CMAP Addendum B. Please refer to Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN) Matters Number MM11814 "July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)" for additional information.

CMAP Addendum B October 2020

An updated PDF and Excel version of Connecticut Medical Assistance Program (CMAP) Addendum B V21.3 has been approved by the Department of Social Services (DSS) and has been added to the Hospital Modernization page on the www.ctdssmap.com Web site.

These changes are effective for dates of service October 1, 2020 and forward. Any procedure code that is "NEW", changed or deleted with an effective date of October 1, 2020 is tentatively scheduled to be updated on November 11, 2020. Any claims with new or changed procedure codes is tentatively scheduled to be identified and reprocessed in the 2nd cycle in December.

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, 2020. Any claims that are submitted for dates of service October 1, 2020 and forward that have a status indicator of G or K will process at the correct payment rate.

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3M Grouper

The update to the ICD-10 (International Statistical Classification of Diseases) codes effective October 1, 2020 may cause inpatient Diagnostic Related Group (DRG) claims with header Through Date of Service (TDOS) October 1, 2020 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 which is tentatively scheduled for November 11, 2020 and any suspended claims will be released in the 2nd cycle in November.

DRG Weight, Average Length of Stay (ALOS) and Outlier Threshold Reminder

The DRG Calculator was updated effective for dates of discharge October 1, 2020 and the only updates were to any added or deleted DRG codes.

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, 2021.

Provider Bulletins

Provider Bulletin 2020-75 - Medical Authorization Portal

Effective December 19, 2020, Community Health Network of Connecticut, Inc. (CHNCT) will transition the current HUSKY Health medical authorization platform and Clear Coverage™ to a new prior authorization (PA) system and medical portal. The new system is a web-based tool that will support the secure exchange of clinical documentation. Please note there will be no changes to the submission of radiology PA requests.

No changes will be made to the services that currently require PA. Services currently requiring PA will continue to require PA. An invitation for hospital to attend web-based training sessions for the new medical authorization portal will be sent to those providers registered and currently using Clear Coverage.

As a reminder, hospital can view approved PAs from their secure portal on the www.ctdssmap.com Web site regardless of the date of submission of the PA.

Provider Bulletin 2020-74 - Policy Updates and Changes to Clinical Review Criteria

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

Policies are available on the HUSKY Health Web site at: https://portal.ct.gov/husky. Prior Authorization (PA) Form Updates; PA forms for Synagis, Whole Exome and Whole Genome Sequencing, and Zulresso have been updated to support policy changes and PA forms for TECARTUS and organ transplant have been created.

To access the policies, click on For Providers followed by Policies, Procedures and Guidelines under the Medical Management menu item. To access the forms, click on For Providers followed by Provider Forms under the Medical Management menu item.

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Provider Bulletin 2020-71 - Addition of Procedure Codes to the Independent Laboratory Fee Schedule and CMAP Addendum B

Retroactive to the applicable dates of service listed below, DSS is adding the following laboratory procedure codes to the Independent Laboratory fee schedule and to the Connecticut Medical Assistance Program (CMAP's) Addendum B.

Procedure Code	Rate	Effective Date
87426	$11.45	6/25/2020
86408	$16.15	8/10/2020
86409	$16.15	8/10/2020
86413	$14.32	9/8/2020
87811	$11.45	10/7/2020
87636	$122.51	10/7/2020
87637	$122.51	10/7/2020

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

Questions

Procedure code C9803 "Hospital COVID-19 Specimen Collection"

DSS) has reviewed this procedure code but will continue to not cover any specimen collection codes. Hospital should continue to refer to CMAP Addendum B to determine which services are covered.

Procedure code Q3014 "Telehealth Facility Fee"

The Department of Social Services is not covering this procedure code at this time. DSS will review for the possibility of future use with policy limits.

Discontinuation of Modifier GD

The use of modifier GD "units of service exceeds medically unlikely edit value and represents reasonable and necessary services" was discontinued based on the Centers for Medicare and Medicaid Services' (CMS) guidance and at this time DSS will continue not to allow Medically Unlikely Edits (MUE) overrides.

Reminders:

Medicare Exhausted Inpatient Claims

Medicaid's payment will be limited to the full coinsurance and/or deductible on an inpatient Medicare crossover claim where Medicare has been exhausted. When Medicare is exhausted during a hospital stay, it is no longer acceptable to cut back the dates of service on the crossover claim and then bill Medicaid directly, via an inpatient claim, for the dates of service after Medicare has been exhausted. The Medicare inpatient crossover claim should be submitted in its entirety to include the total stay. Medicaid's payment will only be for the Medicare coinsurance and/or deductible.

Medicaid will continue to consider the Part B covered charges of an inpatient stay when Medicare has been exhausted. There are no billing changes for these outpatient crossover claims.

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If Medicare Part A denies the entire stay as exhausted the hospital should submit part B charges to Medicare for processing and if Medicare Part B makes a payment, the non-crossover inpatient claim must be billed by indicating the Part A denial and Part B payment. The Part B payment in the paid amount field must equal the sum of the Medicare paid amount, coinsurance amount and the deductible amount located on the Explanation of Medicare Benefits.

When Medicare denies the entire stay as exhausted and the client has Qualified Medicare Beneficiary (QMB) Medicare Covered Services only, there will be no reimbursement for the non-crossover inpatient claim.

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 0878 - Allowed Amount is Zero Manual Priced Outpatient APC.

Cause: Outpatient APC claim with details with Status Indicator (SI) equal to "Q1, Q2, Q3 or Q4" on a manually priced claim with a detail with SI "C", payment rate "MP" and payment type "Surg".

Resolution: Details with SI "Q1 - Q4" will be included in the manually priced amount and will not allow any additional reimbursement. Please verify detail with SI "C" for allowance.

EOB code 0311 - APC - Implanted device without implantation procedure or administered substance without associated procedure

Cause: An outpatient claim was submitted with an APC status indicator of H "pass through device category" or U "Brachytherapy Sources" or APC 987-997 is present, but no procedure codes with status indicator of S, T "significant procedure payable under OPPS", J1 "Hospital Part B services paid through a comprehensive APC" or non-implant type X procedure are present on the claim.

Resolution: Please verify the claim to see if procedure codes with status indicator S, T, J1 or non-implant status indicator X are present on the claim. If missing, add procedure and re-submit the claim.

COVID-19 (Coronavirus) Information and Frequently Asked Questions (FAQs) (Updated 10/21/2020) Important Message

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.

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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.

HOLIDAY CLOSURE

Please be advised DSS will be closed on Wednesday November 11, 2020 in observance of Veterans Day, Gainwell Technologies will be open on Wednesday November 11, 2020.

DSS and Gainwell Technologies will be closed on Thursday, November 26, 2020 in observance of Thanksgiving. Gainwell Technologies will also be closed on Friday, November 26, 2020 in observance of Thanksgiving. DSS will be open on Friday, November 27, 2020

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