interChange Provider Important Message

Hospital Monthly Important Message Updated as of 10/08/2020

*all red text is new for 10/08/2020

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. 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

The Department of Social Services (DSS) will be updating the Connecticut Medical Assistance Program (CMAP) Addendum B 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 will be updated in the near future.

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.

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. 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.

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

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 2020-63 - 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.

Outstanding Questions

Procedure code C9803 "Hospital COVID-19 Specimen Collection"

The Department of Social Services (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.

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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 4227- The RCC Billed is not a covered service under the client's benefit plan.

Cause - The claim was submitted with an RCC for a client with multiple benefit plans, such as HUSKY C, and QMB (Qualified Medicare Beneficiary). The claims processing system will attempt to make payment for the RCC under each benefit plan. If the claim was submitted with the intent to be paid under the client's HUSKY C but denied for other edit messages under that benefit plan, the system will then attempt to make payment under the QMB benefit plan. Edit 4227 will post under the QMB benefit plan when Medicare has denied the claim. A denied claim will contain all edit/audits associated to all benefit plans.

Resolution - no action is required to resolve edit 4227. Action should be taken on any other edit(s) that might set on the claim. Once the other edit(s) are resolved and the claim is resubmitted, the claim should process and pay and the system will not set edit 4227 again. If the client only has QMB and Medicare has denied the claim, the claim was denied correctly with edit 4227.

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.

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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, the Department of Social Services (DSS) will be closed on Monday, October 12, 2020 in observance of the Columbus Day holiday. DSS will re-open on Tuesday, October 13, 2020. Gainwell Technologies will be open on Monday, October 12, 2020.

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