interChange Provider Important Message

Hospital Monthly Important Message Updated as of 01/14/2020

*all red text is new for 01/14/2020

CMAP Addendum B January 2020

The Department of Social Services (DSS) will be updating the Connecticut Medical Assistance Program (CMAP) Addendum B to incorporate the 2020 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) for dates of service January 1, 2020 and forward to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system on January 2, 2020 with a January 1, 2020 effective date for dates of service January 1, 2020 and forward. DXC Technology has determined there were no outpatient claims that processed with the incorrect payment for dates of services January 1, 2020 and forward.

For dates of service January 1, 2020 and forward the outlier dollar threshold has increased from $4,825.00 to $5,075.00.

Any other procedure code adds, changes or deletes with an effective date of January 1, 2020 and forward is tentatively scheduled to be updated on January 28, 2020. A separate communication will go out once the system has been updated.

DRG Calculator

The DRG Calculator has been updated to reflect the DRG Weights, Average Length of Stays (ALOS) and Outlier Thresholds effective for discharge dates January 1, 2020 and forward. DSS has updated the hospital's Adjusted Base Rate, IME Factor, Cost-to-Charge ratio, Behavioral Health and Rehab per diem rates for discharge dates January 1, 2020 and forward. These updates are located under the Provider Table CT tab in the DRG Calculator.

The updated DRG calculator has been added to the Hospital Modernization Web Page.

DRG Weight, Average Length of Stay (ALOS) and Outlier Threshold Updates – January 1, 2020

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, 2020.

Inpatient Diagnostic Related Group (DRG) Claims and Outpatient APC Mass Adjustment

Inpatient DRG and Outpatient APC claims that were previously suspended with Explanation of Benefit (EOB) codes 8182 "Claim Mass Adjusted Due to an APC Change" and 8185 "Claim Mass Adjusted Due to a DRG Change." These claims were adjusted in the 2nd cycle in December and appeared on the December 24, 2019 Remittance Advice (RA).

In cases where the inpatient claim processed at the wrong DRG weight or DRG code the claims were adjusted in the 2nd cycle in December and appeared on the December 24, 2019 Remittance Advice (RA) with EOB 8185 "Claim Mass adjusted Due to a DRG change."

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Inpatient Diagnostic Related Group (DRG) Claims and Outpatient APC claims in Suspended Status

DXC Technology is in the process of reviewing Inpatient DRG and Outpatient APC claims and at this time no claims have been adjusted and there has been no financial impact to the hospitals

Inpatient DRG and Outpatient APC claims that are currently under review will display with a claim status of "Adjusted/Voided" or "Suspended" under claim inquiry on the www.ctdssmap.com Web site. The claim will begin with an ICN# 5520011 or 5520010 and have an Explanation of Benefit (EOB) codes 8182 "Claim Mass Adjusted Due to an APC Change" and 8185 "Claim Mass Adjusted Due to a DRG Change." If there are no changes in processing, these claims will be deselected from this process.

Provider Bulletins

Provider Bulletin 2019-89 - Discontinuation of Modifier GD

Effective for dates of service January 1, 2020 and forward, DSS is discontinuing the use of modifier GD - units of service exceeds medically unlikely edit value and represents reasonable and necessary services. This provider bulletin (PB) supersedes PB 2017-69 - National Correct Coding Initiative (NCCI) – Medically Unlikely Edits Review Process.

The use of modifier GD is being discontinued based on the Centers for Medicare and Medicaid Services' (CMS) guidance. DSS will continue to have a Medically Unlikely Edit (MUE) review process for dates of service on or after January 1, 2020 and will issue future guidance regarding the updated MUE review process.

Provider Bulletin 2019-88 –Annual Update to the Inpatient Hospital Adjustment Factors

Effective for discharges on or after January 1, 2020, the adjustment factor was updated to the All Patient Refined – Diagnosis Related Group (APR-DRG) base payment calculation under State Plan Amendment (SPA) 19-0011 was updated.

Provider Bulletin 2019-78 - Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)

The Department of Social Services (DSS) and DXC Technology have published the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and 835 schedule for January 2020 to June 2020.

Updates to 835 Electronic Remittance Advice (ERA)

EOB code 841 "Units of Measure Required for NDC" is currently tied to CARC 16 "Claim/ service lacks information or has submission/ billing error(s)" and RARC M123 "Missing/incomplete/invalid name, strength, or dosage of the drug furnished" will be changed and will post CARC 16 and RARC N816 "Missing/Incomplete/Invalid NDC Unit of Measure" under business scenario 2.

EOB code 842 "NDC Units Missing or Invalid" is currently tied to CARC 16 and RARC M349 "The administration method and drug must be reported to adjudicate this service" will be changed and will post CARC 16 and RARC N815 "Missing/Incomplete/Invalid NDC Unit Count" under business scenario 2.

EOB code 4149 "Billing provider not authorized to bill for submitted procedure code", **EOB code 4151** "Billing provider not authorized to bill for submitted service for client", and **EOB code 4140** "The service submitted is not covered under the client's benefit plan", is currently tied to CARC 96 "Non-covered charge(s)" and RARC N95 "This provider type/provider specialty may not bill this service." will be changed and will post CARC 299 "The billing provider is not eligible to receive payment for the

service billed" and RARC N95 "This provider type/provider specialty may not bill this service" under business scenario 3

The existing Connecticut Medical Assistance Program (CMAP) EOB Crosswalk located on the www.ctdssmap.com Web site under Publications < Claim Processing Information < Medical Assistance Program EOB Crosswalk Pharmacy and Non-Pharmacy has been updated to reflect these changes.

Hospital Outpatient Flat Fee Schedule

Effective for dates of service January 1, 2020 and forward, DSS has updated the hospital outpatient flat fee rates and the hospital outpatient flat fee schedule will be updated in the near future.

The Hospital Outpatient Flat fee schedules can be accessed and downloaded from the Connecticut Medical Assistance Program Web site www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download". Click on the "I accept" button and proceed to click on the Hospital Outpatient Flat Fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open."

Status Indicator G "Drug Biological Pass Through" and K "Non-Pass-Through Drugs and Biologicals"

If the procedure codes payment type is APC-PR with a status indicator of G or K, it will be reimbursed based on the payment rate on CMAP Addendum B x the number of units up to the detail billed charges. We will pay the lesser of billed charges and the payment rate. We only allow more than the detail amount when the claims process at an APC rate.

HUSKY PLUS Benefit Plan

HUSKY Plus provides supplemental coverage of goods and services for eligible HUSKY B members under the age of 19 years old who have intensive physical health needs and have exhausted one or more of their benefits covered under the HUSKY B plan. When eligibility changes and the client no longer have HUSKY Plus benefit plan and the hospital received a therapy Prior Authorization (PA) under their HUSKY Plus benefit plan, they will be required to get an updated PA for the updated HUSKY benefit plan.

TPL Audit Report - January 2020

The Third-Party Audit reports were sent to the following hospitals on January 3, 2020:

Windham Community Memorial Hospital, and Danbury Hospital.

HOLIDAY CLOSURE

Please be advised, the Department of Social Services (DSS) and DXC Technology will be closed on Monday, January 20, 2020 in observance of the Martin Luther King Jr.'s Day Holiday. DSS and DXC Technology offices will re-open on Tuesday, January 21, 2020.