interChange Provider Important Message

Hospital Monthly Important Message Updated as of 02/10/2020

*all red text is new for 02/10/2020

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.

Any other procedure code adds, changes or deletes with an effective date of January 1, 2020 and forward were updated on January 28, 2020. Any outpatient claims processed between January 1, 2020 and January 28, 2020 with APC weight changes, status indicator changes, "NEW" codes on the CMAP Addendum B are tentatively scheduled to be adjusted in the February 28, 2020 claim cycle.

Inpatient Diagnostic Related Group (DRG) Claims and Outpatient APC claims in Suspended or Adjusted/Voided Status

DXC Technology is in the process of reviewing Inpatient DRG and Outpatient APC claims that were processed prior to the January 2020 DRG and APC Grouper updates that were promoted to the system. These updates were completed on January 28, 2020. The claim selection process started after the February 7, 2020 claim cycle 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# 5520040 or 5520039 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."

In cases where the inpatient claim processed at the wrong DRG weight or DRG code or APC changes occurred the claims are tentatively scheduled to be adjusted in the 2nd cycle in February. Any inpatient or outpatient claims that processed correctly and do not require an adjustment will be deselected and the original claim will change back to a "Paid" Status.

DRG Calculator

The DRG Calculator per the amendment to Attachment 4.19-A of the Medicaid State Plan 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, Indirect Medical Education (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.

Provider Manual Chapter 8 Updated

Provider manual chapter 8 was updated to include procedure 97129 – 97130 under physical therapy codes and 90867 - 90869 under behavioral health codes; modifier GD was removed.

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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.

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 was updated on February 10, 2020.

The Hospital Outpatient Flat fee schedule 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."

1099s Now Available on Web site

DSS and DXC Technology are pleased to announce providers can download their 2019 1099s from the www.ctdssmap.com Web site. This functionality will be available for all Master Users and any subordinate clerk accounts who have access to download PDF Remittance Advice files. The 2019 1099s were also mailed to providers on January 23, 2020.

Providers wishing to download their 2019 1099 from www.ctdssmap.com would do so by logging into their secure Web portal account, selecting Trade Files then download. Providers must then click on the 1099s selection located at the top of the drop-down menu.

As a courtesy, the 2018 1099s will also be loaded to providers' secure Web portal accounts in the middle of February 2020 for historical reference.

Reminders:

Pediatric Inpatient Admissions that Contain Medically Necessary Discharge Delay Days

When the hospital has an inpatient claim with both acute care days and discharge delay days, the hospital should bill one detail line for the acute care days and a second detail line for the discharge delay days using Revenue Center Code (RCC) 224 on one inpatient claim.

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Inpatient Admit Change from Medical to Psychiatric

When a HUSKY client is admitted and the primary reason for the admission is medical in nature, the hospital should request a medical Prior Authorization (PA) from Community Health Network of Connecticut (CHNCT) to process the authorization through discharge. If the client is subsequently transferred to a psychiatric unit, the hospital should administratively discharge (Patient Status 65) the client from medical and re-admit the client to behavioral health (Admit Source D) to qualify for the per diem rate for the behavioral health portion of the stay. Upon re-admission to behavioral health, the hospital should request a per diem PA from Connecticut Behavioral Health Partnership (CT BHP) to process the authorization through discharge. In this case, the hospital must submit two separate inpatient claims, with two different admit dates.

Inpatient Admit Change from Psychiatric to Medical

When a HUSKY client is admitted and the primary reason for the admission is behavioral health, the hospital should request a PA from CT BHP to process the authorization through discharge. If the primary focus of treatment shifts to medical and the client is subsequently transferred to a medical bed, the hospital should administratively discharge the client from behavioral health and re-admit (Admit Source D) the client to medical service. Upon readmission, the hospital should request a PA from CHNCT to process the authorization through discharge to be reimbursed via DRG payment methodology for the medical portion of the stay. In this case, the hospital must submit two separate inpatient claims, with two different admit dates.

Inpatient Admit Change to Rehabilitation Services

If a HUSKY Health Program client, who received a behavioral health authorization or medical authorization upon admission, requires further inpatient rehabilitation care, the hospital should administratively discharge (Patient Status 62) the client from behavioral health or medical and re-admit (Admit Source D) the client for rehabilitation services to qualify for further payment. A per diem PA for acute rehabilitation per diem services should be requested from CHNCT.

Refer to Provider Bulletin 2015-22 Inpatient Hospital Modernization - Per Diem Payments for Rehabilitation and Behavioral Health for additional information.

Provider Manual Chapter 12

EOB Code 0671 - DRG covered/non-covered days disagree with the statement period

Cause: The covered days (value code 80) plus non-covered days (value code 81) does not equal the number of elapsed days based on the admission date and header through date of service. Add 1 to the service days if the patient status is 30 (still a patient).

Resolution: Review the admission date, header through date of service, covered and non-covered days, and patient discharge status to determine which field is in error, correct and resubmit the claim.

EOB code 0674 - DRG interim claims not allowed

Cause: The inpatient claim was submitted with a patient status is 30 (still a patient) and the claim length of stay (LOS) is less than 29 days.

Resolution: If the actual length of an inpatient admission is less than 29 days, the hospital must bill for the entire admission on one claim. If an inpatient claim is submitted with a patient discharge status of 30, indicating the patient is still in the hospital, it will be denied if the number of days submitted is less than 29 days.

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Outpatient Hospital Prior Authorization Grid

The Prior Authorization Grid for Outpatient Hospital grid can be accessed from the Connecticut Medical Assistance Web Site: www.ctdssmap.com. From this web page, go to "Hospital Modernization", then click "Prior Authorization Grid for Outpatient Hospitals".

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.

TPL Audit Report - January 2020

The Third-Party Liability (TPL) Audit reports were sent to the following hospitals on February 3, 2020: Yale New Haven Hospital, and SVMC Holdings.

HOLIDAY CLOSURE

Please be advised, DSS will be closed on Wednesday, February 12, 2020 in observance of Lincoln's Birthday. DSS will re-open on Thursday, February 13, 2020. In addition, DSS and DXC Technology will be closed on Monday, February 17, 2020 in observance of the Presidents' Day holiday. Both DSS and DXC Technology offices will re-open on Tuesday, February 18, 2020.