interChange Provider Important Message

Hospital Monthly Important Message Updated as of 07/12/2019
*all red text is new for 07/12/2019

CMAP Addendum B July 2019

The updated version of the CMAP Addendum B and NEW procedure codes is tentatively scheduled to be updated July 23, 2019 with an effective date of July 1, 2019 and forward.

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system prior to July 1, 2019. Any claims that are submitted for dates of service July 1, 2019 and forward that have a status indicator of G or K will process at the correct payment rate.

Supplemental Payment

For inpatient discharges that occurred between October 1, 2018 and April 14, 2019, a supplemental payment was paid out to the hospitals on July 26, 2019. This payout made up for the difference between what was paid without the adjustment factor and what would have been paid if the adjustment factor was in effect for that period.

DRG Weight, Average Length of Stay (ALOS) and Outlier Threshold Amount Updated 10/1/2018

Inpatient claims with a discharge date of October 1, 2018 to November 13, 2018 that processed at the incorrect DRG weight, ALOS or outlier amount was identified and reprocessed in a special claim cycle Friday June 14, 2019 and appeared on your June 18, 2019 Remittance Advice (RA). The monies due from the special claim cycle was recouped on your June 25, 2019 Remittance Advice (RA) and will be paid back out in the supplemental payment which was paid out separately to the hospital.

Outpatient Claims Billed with Modifier GZ "Not Reasonable and Necessary"

DXC Technology has identified and reprocessed outpatient and outpatient crossover claims that processed between July 25, 2018 and March 26, 2019, contained a procedure code with modifier GZ and denied due to not assigning a status indicator to the procedure code. The impacted claims have been identified and reprocessed with the procedure code tying to the correct status indicator based on CMAP Addendum B. The impacted claims appeared on your July 9, 2019 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

Provider Bulletins

Provider Bulletin 2019-45 – Elimination of Paper Trading Partner Agreements Notification

The purpose of this provider bulletin is to notify all providers and trading partners that effective July 1, 2019, the Department of Social Services (DSS) will no longer accept paper Trading Partner Agreement forms. All transactions going forward, both new and updates, are to be submitted via the www.ctdssmap.com Web portal.

Provider Bulletin 2019-44 – Revision of Rates for Certain Clinical Diagnostic Laboratory Testing Codes

The Department of Social Services (DSS) revised the reimbursement for certain clinical diagnostic laboratory testing on the lab fee schedule to comply with federal Medicaid law (42 U.S.C. § 1396b(i)(7)), which prohibits state Medicaid programs from paying more than Medicare would pay for any laboratory service. The following rates for procedure codes 81316, 82286, 83987 and 86821 rates were updated, and claims billed with dates of services January 1, 2019 and forward that will be adjusted to the updated rate in the 2nd claim cycle in July 2019.

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Provider Bulletin 2019-34 - Expedited Medicaid Eligibility Processing for Individuals with Medical Emergencies

This bulletin is a reminder to providers about the availability of expedited Medicaid eligibility processing for individuals with medical emergencies. An individual may be eligible for emergency Medicaid application processing if the individual has a condition or illness that, if not immediately treated, places the individual at serious and imminent risk of severe harm or permanent disability.

Provider Bulletin 2019-33 - Updating the Tuberculosis Limited Benefit

This policy transmittal supersedes PB 11-73 "New Tuberculosis Eligibility Group and Changes to the Home Health Fee Schedule". This policy transmittal (1) updates the guidance for billing for services under the TB Limited Benefit program and (2) outlines changes to the coding for direct observation therapy.

Provider Bulletin 2018 - 39 - Diagnostic Related Group (DRG) Coding Reviews

Department of Social Services (DSS) in conjunction with its contractor Health Management Systems, Inc. (HMS) started conducting post payment reviews of inpatient hospital claims paid under a Diagnostic Related Group (DRG) methodology. The post payment reviews are being completed to ensure DSS is reimbursing the proper amount for these claims in conformance with Medicaid and DSS policy.
For claims identified as improperly overpaid by HMS, DSS will initiate a full recoupment of the claim payment and hospitals will be required to resubmit a new claim to DSS with the corrected coding as provided on HMS's findings report. These claims can be identified by Internal Control Numbers beginning with 60. If hospitals have any questions, please contact CT_Medicaid_State@hms.com.

Hospital Refresher Workshop Material

The hospital refresher workshop material is available on www.ctdssmap.com Web site under the Hospital Modernization page under "Provider Training" on the right side of the page. Once on the training page click on the hospital workshops link under materials to download the hospital refresher workshop power point which included information on APC and DRG processing.

Medicare Covered Services Only - Qualified Medicare Beneficiary (QMB)

If the client is Qualified Medicare Beneficiary (QMB) Medicare Covered Services only, they can bill the client for non-covered services since Medicaid only considers the claim as secondary when there is a Medicare co-insurance and/or deductible amounts.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf for additional information. If the hospital is determining whether to bill the clients for Inpatient Part A claims denied by Medicare due to benefits being exhausted, the hospital needs to contact the Centers for Medicare & Medicaid Services (CMS) for guidance.

TPL Audit Report – July 2019

The Third Party Audit reports were sent to the following hospitals on July 2, 2019:

Yale New Haven Hospital, Day Kimball Hospital, Bristol Hospital, Bridgeport Hospital, and The Charlotte Hungerford Hospital.

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Inpatient Hospital Fee Schedule for Organ Acquisition Costs

The table below contains historical and current Organ Acquisition rates for both in- and out-of-state hospitals for Revenue Center Code (RCC) 810, 811 and 812.

Organ	Flat Fee	Effective date	End date
Kidney	$91,504	7/1/2019	12/31/2299
Heart	$120,727	7/1/2019	12/31/2299
Liver	$168,347	7/1/2019	12/31/2299
Pancreas	See Below	7/1/2018	12/31/2299
Lung	See Below	1/1/2015	12/31/2299

Payment will be the lower of charges or state wide average.
*For lung or pancreas acquisition, the hospital must submit their most recent Medicare cost report submitted to CMS.