interChange Provider Important Message

Hospital Monthly Important Message Updated as of 08/13/2019

*all red text is new for 08/13/2019

CMAP Addendum B July 2019

The updated version of the CMAP Addendum B and NEW procedure codes was updated on 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.

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 2019-53 – Updates to Genetic Testing Prior Authorization Form

Effective September 1, 2019 and forward, the Genetic Testing Prior Authorization (PA) Request Form has been updated. The updated form should be used beginning September 1, 2019.

PA request forms are available on the HUSKY Health Web site at: www.ct.gov/husky. To access the forms, click on For Providers, followed by Prior Authorization Forms and Manuals under the Prior Authorization menu item.

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.

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.

Inpatient Delivery Stay

Inpatient delivery stays denying due to lack of prior authorization when the delivery stays do not require prior authorization. The Department of Social Services' (DSS) criterion for identifying a delivery for an inpatient stay is based on the primary diagnosis code on the claim. If the primary reason for the stay was a delivery, then Prior Authorization (PA) is not required. DSS has determined that there were ICD-10 diagnosis codes that should have bypassed the PA requirement on an inpatient delivery stay.

Diagnosis codes that were denied by DSS, either had a childbirth specific diagnosis code in the series, which is the appropriate code to use instead of the trimester code (i.e. O10.013 "Pre-existing essential hypertension complicating pregnancy, third trimester", if there was a delivery the hospital should use O10.02 "Pre-existing essential hypertension complicating childbirth" or were denied because the diagnosis code in question should not be considered as the primary code on the claim. In other circumstances, the hospital should be using a more specific code under ICD-10 versus selecting "unspecified".

If the hospital still believes there are other diagnoses that should be considered to bypass PA when a delivery occurs, please send claim examples (including ICN) to DXC Technology at the following e-mail address: ctxixhosppay@dxc.com.

TPL Audit Report – August 2019

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

Midstate Medical Center, Danbury Hospital, Johnson Memorial Hospital, Windham Community Memorial Hospital, Hartford Hospital, and The Hospital of Central Connecticut.

Provider Manual Chapter 12 – Claim Resolution Guide

Provider manual chapter 12 provides a detailed description of the cause of each Explanation of Benefits (EOB) and more importantly the necessary directions to resolve the error. This guide also provides where hospital can go to find additional information to assist with correcting their claims.

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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.

HOLIDAY CLOSURE: Please be advised that the Department of Social Services (DSS) and DXC Technology will be closed on Monday, September 2, 2019 in observance of the Labor Day holiday. Both DSS and DXC Technology offices will re-open on Tuesday, September 3, 2019.