interChange Provider Important Message

Hospital Monthly Important Message Updated as of 12/9/2020

*all red text is new for 12/9/2020

CMAP Addendum B October 2020

An updated PDF and Excel version of Connecticut Medical Assistance Program (CMAP) Addendum B V21.3 has been approved by the Department of Social Services (DSS) and has been added to the Hospital Modernization page on the www.ctdssmap.com Web site.

These changes are effective 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 was updated on November 11, 2020. Any claims with new or changed procedure codes are tentatively scheduled to be identified and reprocessed in the 2nd cycle in December.

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 caused 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. The new 3M grouper was loaded on November 11, 2020 and any suspended claims were released in the 2nd cycle in November and appeared on your Remittance Advice dated November 24, 2020.

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

The DRG Calculator was updated effective for dates of discharge October 1, 2020 and forward and the only updates were to added or deleted DRG codes.

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 2020-84- CMAP COVID-19 Response - Bulletin 42: Clarifying Guidance for Speech and Language Pathology Telemedicine Services Stated in PB 2020-23 and 2020-24

As stated in Provider Bulletin (PB) 2020-23 and PB 2020-24, effective for dates of service March 20, 2020 until DSS has notified providers in writing that the state has deemed COVID-19 no longer to be a public health emergency, the following Speech & Language Pathology (SLP) procedure codes may be rendered via telemedicine; 92507, 92521, 92522 and 92523.

During the Temporary Effective Period, DSS is adding Revenue Center Code (RCC) 444 – "SLP Evaluation and Re-evaluation" as an allowable telemedicine service. RCC 444 must be billed with an applicable procedure code also approved to be rendered via telemedicine

interChange Provider Important Message

Provider Bulletin 2020-82 - Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)

The Department of Social Services (DSS) and Gainwell Technologies 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 2021 to June 2021.

Provider Bulletin 2020-79 - Removal of Prior Authorization from Electroconvulsive Therapy Services

Effective for dates of service January 1, 2021 and forward, the Department of Social Services (DSS) is removing Prior Authorization (PA) on procedure code 90870 "Electroconvulsive therapy" that is listed on the Clinic and Outpatient Hospital Behavioral Health fee schedule and on the Connecticut Medical Assistance Program (CMAP) Addendum B.

Hospitals must continue to refer to both CMAP Addendum B and the Clinic and Outpatient Hospital Behavioral Health fee schedule for PA requirements

Provider Bulletin 2020-75 - Medical Authorization Portal

Effective December 19, 2020, Community Health Network of Connecticut, Inc. (CHNCT) will transition the current HUSKY Health medical authorization platform and Clear Coverage™ to a new prior authorization (PA) system and medical portal. The new system is a web-based tool that will support the secure exchange of clinical documentation. Please note there will be no changes to the submission of radiology PA requests.

No changes will be made to the services that currently require PA. Services currently requiring PA will continue to require PA. An invitation for hospital to attend web-based training sessions for the new medical authorization portal will be sent to those providers registered and currently using Clear Coverage.

As a reminder, hospital can view approved PAs from their secure portal on the www.ctdssmap.com Web site regardless of the date of submission of the PA.

Reminders:

Medicare Exhausted Inpatient Claims

Medicaid's payment will be limited to the full coinsurance and/or deductible on an inpatient Medicare crossover claim where Medicare has been exhausted. When Medicare is exhausted during a hospital stay, it is no longer acceptable to cut back the dates of service on the crossover claim and then bill Medicaid directly, via an inpatient claim, for the dates of service after Medicare has been exhausted. The Medicare inpatient crossover claim should be submitted in its entirety to include the total stay. Medicaid's payment will only be for the Medicare coinsurance and/or deductible.

Medicaid will continue to consider the Part B covered charges of an inpatient stay when Medicare has been exhausted. There are no billing changes for these outpatient crossover claims.

If Medicare Part A denies the entire stay as exhausted the hospital should submit part B charges to Medicare for processing and if Medicare Part B makes a payment, the non-crossover inpatient claim must be billed by indicating the Part A denial and Part B payment. The Part B payment in the paid amount field must equal the sum of the Medicare paid amount, coinsurance amount and the deductible amount located on the Explanation of Medicare Benefits.

interChange Provider Important Message

When Medicare denies the entire stay as exhausted and the client has Qualified Medicare Beneficiary (QMB) Medicare Covered Services only, there will be no reimbursement for the non-crossover inpatient claim.

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 0878 - Allowed Amount is Zero Manual Priced Outpatient APC.

Cause: Outpatient APC claim with details with Status Indicator (SI) equal to "Q1, Q2, Q3 or Q4" on a manually priced claim with a detail with SI "C", payment rate "MP" and payment type "Surg".

Resolution: Details with SI "Q1 - Q4" will be included in the manually priced amount and will not allow any additional reimbursement. Please verify detail with SI "C" for allowance.

Medically Unlikely Edits (MUEs)

MUE updates are not published on the www.ctdssmap.com Web Site and providers are asked to refer to the National Correct Coding Initiative (NCCI) Edit files by clicking on the link below to obtain published quarterly additions, deletions, and revisions to MUE values and Procedure-to-Procedure (PTP) edits:
https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

Please refer to provider bulletin 17-69 "National Correct Coding initiative (NCCI) - Medically Unlikely Edits Review Process" for additional information.

Billing of Influenza Vaccines for the 2020-2021 Influenza Season Important Message

Gainwell Technologies would like to remind hospitals of the importance of reporting the correct Healthcare Common Procedure Coding System (HCPCS) code for each vaccine product being billed to the Connecticut Medical Assistance Program (CMAP). If the 11-digit National Drug Code (NDC) reported on the claim does not correspond to the vaccine code reported on the same claim detail, the vaccine will be denied. As a reminder, hospitals are asked to submit the Outer Carton NDC when billing vaccine products.

Please refer to the important message from the home page at www.ctdssmap.com for additional links and resources to assist hospitals with selecting the correct HCPCS code for each vaccine billed.

COVID-19 (Coronavirus) Information and Frequently Asked Questions (FAQs) (Updated 10/21/2020) Important Message

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.

interChange Provider Important Message

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.

Hospitals who wish to submit Trauma Questionnaire Responses may fax them to 1-833-577-3519 or email them to CTXIX-TraumaMailbox@dxc.com.

TPL Audit Report - December 2020

The Third-Party Audit reports were sent to the following hospitals on December 1, 2020:

Midstate Medical Center, Hartford Hospital, Charlotte Hungerford Hospital, Windham Community Memorial Hospital, St. Mary's Hospital, The Hospital of Central Connecticut, Gaylord Hospital, Yale New Haven Hospital and Greenwich Hospital.

Re-enrollment Reminder for Hospitals

The hospitals are reminded to take note of their re-enrollment due date with CMAP. Failure to complete and submit their re-enrollment application in enough time to allow for review by DSS by **the re-enrollment due date** will cause the hospital to be dis-enrolled on the re-enrollment due date and no claims after that date will be allowed until the re-enrollment is completed.

This will impact claims processing and the hospitals' ability to verify eligibility until the re-enrollment has been completed.

The following hospitals have re-enrollment due dates coming up in the near future:

- John Dempsey Hospital – inpatient and Outpatient Hospital – 02/09/2021

HOLIDAY CLOSURE

Please be advised that Gainwell Technologies will be closed on Thursday December 24, 2020 and DSS and Gainwell Technologies will be closed on Friday December 25, 2020 in observance of Christmas. DSS and Gainwell Technologies will also be closed on Friday January 1, 2021 in observance of the New Year's Day holiday.