

May 21, 2020

Hospital Refresher Workshop

**Presented by
The Department of Social Services
& DXC Technology
Presenter Paul Tom**

Training Topics

- **Telemedicine and Audio-Only (Telephonic) Services**
- **Prior Authorization**
- **CMAP Addendum B**
- **Provider Fee Schedule**
- **All Patient Refined-Diagnostic Related Group (APR DRG)**
- **Discharge Delay Days**
- **Regulations and Policies**
- **Frequent Claim Denials**
- **Resources**
- **Questions**

Telemedicine Services

- Effective for dates of service March 13, 2020 and forward, the Department of Social Services (DSS) will implement medical and behavioral health services of specified synchronized telemedicine, which is defined as an audio and video telecommunication system with real-time communication between the patient and practitioner.
- Telemedicine services are covered under the Connecticut Medical Assistance Program (CMAP) only when they:
 - Are medically necessary, in accordance with the statutory definition of medical necessity in section 17b-259b of the Connecticut General Statutes.
 - Are rendered via a HIPAA-compliant, real time audio and video communication system (but note that certain popular video chatting software programs are not HIPAA-compliant).
 - Comply with all CMAP requirements that would otherwise apply to the same service performed face-to-face (in-person), including, but not limited to, enrollment, scope of practice, licensure, documentation, and other applicable requirements.
 - Services are covered on CMAP Addendum B and all inclusive to the hospital, no professional services can be billed separately.

Telemedicine Services

BILLING AND DOCUMENTATION GUIDELINES

- Reimbursement/payment rates for telemedicine services are the same as for equivalent in-person services and based on the CMAP Addendum B and the hospital's Fee Schedule.
- Documentation must be maintained by both the originating site provider and the distant site provider to substantiate the services provided. Originating site documentation must indicate the member received or has been referred for telehealth services.
 - Originating site - the physical location of the CMAP member when the member receives telemedicine services.
 - Distant site - the physical location of the CMAP practitioner/provider who is performing the telemedicine service.
- If a telehealth service cannot be provided or completed for any reason, such as due to technical difficulty, the hospital shall not submit a claim.
- Hospitals should continue to bill telemedicine services as an outpatient claim.
- Behavioral Health Services are considered all inclusive services and professional services should not be billed separately.

Telemedicine Services

BILLING AND DOCUMENTATION GUIDELINES

- The following categories of medical services described below are eligible for payment when rendered via telemedicine, but cannot be billed by the hospital and should be billed by the individual physician or physician group.
 - Established Patient Evaluation and Management (E/M) Services 99211-99215.
- The following modifier(s) must be billed on services that were rendered via telemedicine.
 - Modifier “GT” is used when the member’s originating site is located in a healthcare facility or office.
 - Modifier “95” is used when the member is located in the home.
- For additional information on telemedicine services refer to provider bulletin 2020 – 09 “New Coverage of Specified Telemedicine Services Under the Connecticut Medical Assistance Program (CMAP).”

Telemedicine Services

Group Therapy General Guidelines.

- Group psychotherapy can only be billed for members who have completed a psychiatric diagnostic evaluation, admitted to treatment and determined to need the applicable group psychotherapy level of care, as documented in the plan of care.
- Comply with all CMAP requirements that would otherwise apply to the same service performed face-to-face, provider must obtain verbal consent to treat in a group psychotherapy setting using telemedicine from each member and document such consent in the medical record and must conduct group psychotherapy using telemedicine in a private setting and advise members receiving group psychotherapy about privacy precautions.

RCC	Billable CPT/HCPC Code	Description
915	90853	Group Therapy
916	90849	Multi-family Group Psychotherapy
905	S9480	IOP - Psychiatric
906	H0015	IOP - Chemical Dependency
913	H0035	Partial Hospitalization program

- The following covered services are in effect until the state has deemed that COVID-19 is no longer a public health emergency or the Department otherwise determines that some or all of these specific measures are no longer needed, as communicated in writing through subsequent provider communications disseminated by DSS.

Telemedicine Services

Autism Spectrum Disorder (ASD) Direct Observation and Direction.

- Licensed Behavior Analysts (also known as Board Certified Behavior Analysts (BCBAs)) and other licensed practitioners who are already authorized to provide ASD services under Medicaid may perform the Direct Observation and Direction services via telemedicine when a technician is delivering treatment services in the home of a member.
- Direct Observation and Direction may also be billed when all three individuals (member, technician and BCBA or licensed practitioner) are simultaneously using the same telemedicine platform to deliver the ASD treatment service and observe the technician providing the ASD treatment services.
- All telemedicine services for ASD are in effect until DSS has notified providers in writing that the state has deemed COVID-19 no longer to be a public health emergency or DSS otherwise determines in writing that some or all of these specific measures are no longer needed to help protect the public health.

Telemedicine Services

Physical Therapy (PT), Occupational Therapy (OT) and Speech and Language Pathology (SLP) services.

- Effective for dates of service from 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 “Temporary Effective Period”), specified PT, OT and SLP services will be permissible to be rendered to established patients only when rendered via synchronized telemedicine.
 - The following services are approved to be rendered via telemedicine 96125, 97010, 97012, 97014, 97016, 97018, 97022, 97110, 97112 – 97113, 97129 - 97130, 97533, 92507, 92521 – 92523.
 - RCCs 421 (PT visit), 431 (OT visit) and 441 (SLP visit) must continue to be billed by the hospital when PT, OT or SLP services are rendered via telemedicine.
 - For telemedicine services the hospital must append the telemedicine modifier (GT or 95) to the outpatient claim.
- PT, OT and SLP services are paid as an all inclusive rate to the hospital and professional services cannot be billed separately.
- PT, OT and SLP evaluations cannot be rendered via telemedicine.

Telephonic (Audio-Only) Services

- In response to concerns over the spread of COVID-19, effective March 18, 2020 until otherwise notified by DSS in writing, select services for established patients rendered via the telephone or other audio only modalities will be covered by CMAP.

Description	Billable CPT/HCPC Code	Rate
Telephone assessment and management service, 11-20 minutes of medical discussion.	98967	\$50.95
Telephone assessment and management service, 21-30 minutes of medical discussion.	98968	\$55.95

- CPT codes 98967 and 98968 may be billed together on the same date of service for the same member by the same provider, but only if the duration of the telephone call exceeds 41 minutes.
- A member does not need the diagnosis or symptoms of COVID-19 to access these services via the telephone. To the extent applicable, providers must comply with applicable state laws regarding telehealth and scope of practice.
- Hospitals can refer to provider bulletin 20-14 “CMAP COVID-19 Response – Bulletin 4: Expanded Telemedicine and New Audio-Only (Telephonic) Services” for additional information.

Telephonic (Audio-Only) Services

- All coverable services that can be performed as telemedicine may be done via telephone (audio only) for established patients only under this policy using the CPT codes listed above to indicate that the service was done via the telephone.
- PT, OT and SLP telemedicine services are not eligible to be performed via audio-only.
- For example, if you are performing telephonic services for Psytch pt &/family for 30 minutes, you would bill Revenue Center Code 914 with procedure code 98968 with one (1) unit of service.
- For telephonic services, providers do not need to include modifier 95 or GT to identify where the member was located.

Telephonic (Audio-Only) Services

- Per provider bulletin 2020-44 “CMAP COVID-19 Response – Bulletin 30: Updated Audio-Only Behavioral Health (Telephonic) Services - NEW Billing Guidance” Effective for dates of service (DOS) on or after May 11, 2020, until the state deems COVID-19 to no longer be a public health emergency (the Temporary Effective Period) the following procedure codes can be used to bill BH services for both new and established patients. The identified modifier CR “Catastrophe Related Claims” must be submitted on the claim to signify that the services are rendered via audio-only (telephone). Procedure codes 98967 and 98968 should not longer be used on or after May 11, 2020.

Procedure Code	Mod	Description
90791	CR	Psych Diag Eval
90792	CR	Psych Diag Eval with E&M
90832	CR	Psytx w pt 30 minutes
90833	CR	Psytx w pt w/e&m 30 min
90834	CR	Psytx w pt 45 minutes
90836	CR	Psytx w pt w/e&m 45 min
90837	CR	Psytx w pt 60 minutes
90838	CR	Psytx w pt w/e&m 60 min
90847	CR	Family psytx w/pt 50 min
90846	CR	Family therapy w/o pt 50 min

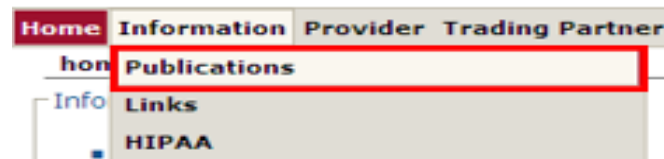
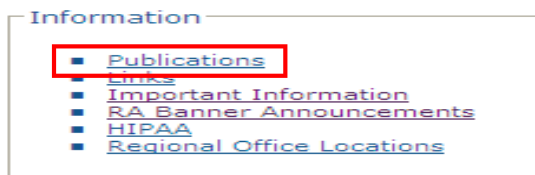
- All of these services will be paid at the same rate as the equivalent in-person services when rendered as an audio-only service.

Telephonic (Audio-Only) Services

- Providers must adhere to the following guidelines when billing telephonic services only.
- Providers must obtain verbal informed consent from the member before providing services via the telephone and document such consent in the medical record. The provider must ensure each member is aware they can opt-out or refuse services at any time.
 - If the member is a minor child, a parent or legal guardian must provide verbal informed consent before providing services via the telephone.
 - Providers must develop and implement procedures to verify provider and patient identity.
 - Providers must document completely for the service billed, including a notation that the service was rendered via the telephone and follow current documentation requirements for the type of service being billed.
 - If a service cannot be provided or completed for any reason, such as due to technical difficulty, providers shall not submit a claim.

Provider Bulletins

- Provider bulletins are available to specific provider types documenting changes and/or updates to CMAP.
- Provider bulletins are available on the www.ctdssmap.com Web site from the Publications page.
- Providers can access the Publications page by selecting Publications from either the Information box on the left hand side of the Home page or from the Information drop-down menu.




Provider Bulletins

- Provider bulletin search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000.

Home **Information** Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification

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Bulletin Search

Year Provider Type

Number Title

Information

Search Results

Bulletin Number	Title	Published Date
PB20-43	CMAP COVID-19 Response - Bulletin 28: Emergency Medicaid for Non-Citizens	04/30/2020
PB20-42	CMAP COVID-19 Response - Bulletin 27: New COVID-19 Coverage Group for Uninsured ...	04/30/2020
PB20-39	CMAP COVID-19 Response - Bulletin 25: Non-Emergency Medical Transportation and N...	04/13/2020
PB20-38	CMAP COVID-19 Response - Bulletin 26: Additional Changes to the Synchronized Tel...	04/16/2020
PB20-33	CMAP COVID-19 Response - Bulletin 23: Changes to the Prior Authorization Require...	04/13/2020
PB20-25	CMAP COVID-19 Response - Bulletin 10: Expanded Use of Synchronized Telemedicine ...	03/26/2020
PB20-23	CMAP COVID-19 Response - Bulletin 8: Emergency Temporary Telemedicine Coverage ...	03/24/2020
PB20-15	CMAP COVID-19 Response - Bulletin 5: Elimination of Copayments for Services Rend...	03/18/2020
PB20-14	CMAP COVID-19 Response - Bulletin 4: Expanded Telemedicine and New Audio-Only (T...	03/19/2020
PB20-13	CMAP COVID-19 Response - Bulletin 3: Emergency Pharmacy Program Changes	03/17/2020
PB20-12	CMAP COVID-19 Response - Bulletin 2: Laboratory Testing Coverage	03/16/2020
PB20-10	CMAP COVID-19 Response - Bulletin 1: Emergency Temporary Telemedicine Coverage	03/11/2020

Prior Authorization

As an interim measure in response to the Governor's recent declaration of a public health emergency as the result of the outbreak of COVID-19 (coronavirus), the Department of Social Services (DSS) is temporarily changing the prior authorization (PA) requirements for specified services effective for dates of service April 1, 2020 until DSS has notified providers in writing that the state has deemed COVID-19 to no longer to be a public health emergency (the "Temporary Effective Period").

Inpatient Admissions

- During the Temporary Effective Period, all in-state and border hospital admissions will not require PA. This applies to all inpatient general acute care hospitals, children's hospitals, chronic disease hospitals and freestanding psychiatric hospitals.
- During the Temporary Effective Period, when a member is admitted medically and requires further behavioral health or rehabilitation care, the separate per diem PA will no longer be required in order for the hospital to receive the inpatient per diem rate and when they are admitted as behavioral health or rehabilitation care and then requires further medical care it doesn't require a separate authorization.

Prior Authorization

- All inpatient behavioral health and rehabilitation services continue to remain an all-inclusive payment to the hospital therefore, professional services cannot be billed separately.
 - Any inpatient admission that is either billed with Revenue Center Code (RCC) 124 or 126 and/or assigned a DRG of 740-776 (behavioral health) will pay at the hospital's behavioral health per-diem rate.
 - Any inpatient admission billed with Revenue Center Code (RCC) 128 and/or assigned a DRG 860 (rehabilitation) will be paid the hospital's Rehab per diem rate

Outpatient Hospitals

- Outpatient Behavioral Health and Advanced Radiology and Imaging services PA requirements will be waived during the temporary effective period for outpatient hospitals.
- For a full list of procedure codes for which the PA and registration requirements are waived please refer to provider bulletin 2020-33 "CMAP COVID-19 Response - Bulletin 23: Changes to the Prior Authorization Requirements for Specified Services.

CMAP Addendum B

- CT Medicaid's Outpatient Prospective Payment System (OPPS) processing is based on the CMAP version of Addendum B which is derived from Medicare's Addendum B. The differences between the CMAP version of Addendum B and the Medicare version of Addendum B primarily involve detail service coverage and pricing methodology.
 - Please refer to CMAP's Addendum B to determine which services will be paid based on fixed fee, fee schedule or APC assignment

The CMAP Addendum B can be found on the "Hospital Modernization" page on the Web site www.ctdssmap.com under Important Messages – Connecticut Hospital Modernization.

CMAP Addendum B

CMAP Addendum B April 2020 V20.2

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
22846	Insert spine fixation device	C			MP	SURG		
23125	Removal of collar bone	J1	05113	33.8823	\$2,737.45	APC		
23200	Resect clavicle tumor	C				No		
58300	Insert intrauterine device	E1			\$165.93	PR		
58321	Artificial insemination	T	05412	3.3508	\$270.72	No		
71045	X-ray exam chest 1 view	Q3	05521	0.9878	\$79.81	APC		
77061	Breast tomosynthesis uni	E1				FS	PHRAD	
77066	Dx mammo incl cad bi	A				RCC	RCC 401	
77067	Scr mammo bi incl cad	A				RCC	RCC 403	
85025	Complete cbc w/auto diff wbc	Q4				APC-FS		
85060	Blood smear interpretation	B				NP		
87635	Sars-cov-2 covid-19 amp prb	A				FS	LAB	New
90471	Immunization admin	Q1	05692	0.7484	\$60.47	RCC	RCC 771	
90586	Bcg vaccine intravesical	B				FS	OFOUT	
93320	Doppler echo exam heart	N				APC		
97010	Hot or cold packs therapy	A				RCC	Therapy RCC	
C9053	Inj, crizanlizumab-tmca	G	09342		\$24.28	APC-PR		New
C9054	Injection, lefamulin	G	09332		\$0.72	APC-PR		G K
J3380	Injection, vedolizumab	K	01489		\$20.17	APC-PR		G K
S9480	Intensive outpatient psychia					FS-CMAP	Clinic/Op - BH if RCC = 905	
U0001	2019 nCoV diagnostic P	A				FS	LAB	New
U0002	COVID-19 lab test non-CDCá	A				FS	LAB	New
U0003	Infectious agent detection by n					FS	LAB	New
U0004	2019-nCoV Coronavirus, SARS					FS	LAB	New

CMAP Addendum B

Payment Type - APC

- If the payment type is APC Payment, it will be reimbursed using APC methodology
- Example: Procedure code 99283 “Emergency dept visit”, payment type indicator “APC”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
99283	Emergency dept visit	J2	05023	2.7643	\$223.34	APC		

- APC Payment = (Provider Wage Adjusted Conversion Factor * units) * APC Relative Weight.
 - If the hospital’s wage adjusted conversion factor was \$85.00, the APC allowance would be $(\$85.00 \times 1) \times 2.7643 = \234.96 .

CMAP Addendum B

Payment Type - APC – FS

- Example: Procedure code 36415 “Routine Venipuncture”, payment type “APC-FS” and status indicator “Q4”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
36415	Routine venipuncture	Q4				APC-FS		
80047	Metabolic panel ionized ca	Q4				APC-FS		

- If the APC grouper returns the service as APC payable, this case will be reimbursed based on payment type “APC-FS” using the CT lab fee schedule.
- If the APC grouper returns a status indicator “N” the detail will be packaged and zero pay (no separate reimbursement).

CMAP Addendum B

Payment Type - NP – These services are only reimbursed when non-patient and will pay off LAB fee schedule.

- Example: Procedure code 80050 “General health panel” payment type “NP”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
80050	General health panel	E1				NP		
83992	Assay for phencyclidine	E1				NP		
85060	Blood smear interpretation	B				NP		
86910	Blood typing paternity test	E1				NP		
86911	Blood typing antigen system	E1				NP		

CMAP Addendum B

Status indicator is “Q1, Q2, Q3 or Q4” on CT Addendum B, but the APC grouper could return detail line with an “N” status.

- Q1 – STVX-Packaged Codes
- Q2 – T-Packaged Codes
- Q4 – Conditionally Packaged Laboratory Tests
 - If there is another procedure code on the outpatient claim that is APC payable, the APC grouper usually would return a status indicator of “N” and the detail will be packaged. The detail will zero pay.
 - Services are only reimbursed when a non-patient and will pay off LAB fee schedule.
- Q3 – Codes that could be paid through a composite APC
 - The procedure with SI “Q3” could pay with a different APC code from CMAP Addendum B.

CMAP Addendum B

- **Procedure codes with status indicator “Q3”**
- When payable separately from the APC payable procedure code on an outpatient claim will normally pay at the APC code list on the CMAP addendum B. If those procedures are billed with other procedures with status indicator “Q3” it could be paid through a composite APC code 08004-08008 which is not listed on CMAP Addendum B. The APC payment would be based on the composite APC weight, not the APC listed on the CMAP Addendum B.
- Example: Procedure code 70551 “Mir brain stem w/o dye”, payment indicator “APC” and status indicator “Q3”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
70551	Mri brain stem w/o dye	Q3	05523	2.8844	\$233.04	APC		

➤ APC grouper returns SI “S” and it will pay based on APC 05523 and relative weight 3.0121

APC Information								
Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
1	S	05523	18.0.0	1	100%	\$238.29	\$0.00	\$238.29

CMAP Addendum B

- Example: Procedure code 70551 “MRI brain stem w/o dye”, billed with procedure code 72146 and both procedures on CMAP Addendum B state payment type “APC” and status indicator “Q3”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
70551	Mri brain stem w/o dye	Q3	05523	2.8844	\$233.04	APC		
72146	Mri chest spine w/o dye	Q3	05523	2.8844	\$233.04	APC		

- The claim goes through the APC grouper and 70551 status indicator is “S” with composite APC 08007 and 72146 status indicator is “N” packaged.
- APC payment would be based on the composite APC code.
- Explanation of Benefit (EOB) code 0013 “Composite APC Applied” will set on that detail.

APC Information									
Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount	
1	S	08007	18.0.0	1	100%	\$581.98	\$0.00	\$581.98	
2	N		18.0.0	0	0%	\$0.00	\$0.00	\$0.00	

CMAP Addendum B

Comprehensive APC codes are listed on CMAP Addendum B.

Status Indicator “J1” could pay the APC code on the CMAP addendum B, but if it is billed with other services it can be paid through a comprehensive APC code which might be listed on CMAP Addendum B for another code.

- Example: Procedure code 28300 “Incision of heel bone”, payment indicator “APC” and status indicator “J1”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
28300	Incision of heel bone	J1	05114	74.0404	\$5,981.95	APC		

➤ J1 – Hospital Part B Services Paid through a Comprehensive APC.

➤ When billed by itself the APC grouper returns SI “J1” and it will pay based on APC 05114 and relative weight 74.0404.

CMAP Addendum B

- Example: Procedure code 28300 “Incision of heel bone”, payment indicator “APC” and status indicator “J1” is billed with procedure code 28238 “Revision of foot tendon”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
28238	Revision of foot tendon	J1	05114	74.0404	\$5,981.95	APC		
28300	Incision of heel bone	J1	05114	74.0404	\$5,981.95	APC		

- The claim goes through the APC grouper and 28300 status indicator is “J1” with comprehensive APC 05115 and 28238 status indicator is “N” packaged.
- APC payment would be based on the comprehensive APC code.

Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
N		19.0.0	0	0%	\$0.00	\$0.00	\$0.00
J1	05115	19.0.0	1	100%	\$11,580.68	\$0.00	\$11,580.68

CMAP Addendum B

- Example: Procedure code 99284 “Emergency dept visit”, payment indicator “APC” and status indicator “J2” is billed with procedure code G0378 “Hospital observation per hr”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
99284	Emergency dept visit	J2	05024	4.3542	\$361.79	APC		
G0378	Hospital observation per hr	N				APC		

- The claim goes through the APC grouper and 99284 status indicator is “J1” with comprehensive APC 08011 and G0378 status indicator is “N” packaged.
- APC payment would be based on the comprehensive APC code 08011.
- Explanation of Benefit (EOB) code 0014 “Comprehensive APC Applied” will set on that detail.

Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
J2	08011	20.0.0	1	100%	\$2,660.94	\$0.00	\$2,660.94
N		20.0.0	0	0%	\$0.00	\$0.00	\$0.00

CMAP Addendum B

Status Indicator and APC Relative Weights

- The relative weights used on the CMAP Addendum B are received from the Centers for Medicare & Medicaid Services (CMS) under Addendum A and Addendum B updates on the CMS Web site.
- The hospital can use the following link to get to the site:
 - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>
- Then select the most current Addendum A or Addendum B link April 2019, then click on “Accept” then “Open” and then select either “2019 April Web Addendum A 03.22.19” for relative weights or “2019 April Web Addendum B 03.22.19” for the Medicare’s status indicator in excel or text format.
- The list of status indicators are located on the on the CMS Web site under Addendum D1 and the hospital can use the following link to get to the site:
 - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1506FC_Addendum_D1.pdf

CMAP Addendum B

Payment Type APC-PR – Line item paid based on CMS payment rate.

- Example: Procedure code C9053 “Inj, crizanlizumab-tmca”, payment type “APC-PR” and J1610 “Glucagon hydrochloride/1 mg.”

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
C9053	Inj, crizanlizumab-tmca	G	09342		\$24.28	APC-PR		New
J1610	Glucagon hydrochloride/1 mg	K	09042		\$199.88	APC-PR		G K

- Status Indicator G “Drug Biological Pass Through” and K “Non-Pass Through Drugs and Biologicals”
 - If the procedure code 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 lesser of billed charges versus the payment rate x units.

CMAP Addendum B

Payment Type – FS – Line item paid based on CT policy (CT fee schedule payment).

- Example: Procedure code 77062 “Breast tomosynthesis bi”, payment type “FS”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
77061	Breast tomosynthesis uni	E1				FS	PHRAD	
77062	Breast tomosynthesis bi	E1				FS	PHRAD	
77063	Breast tomosynthesis bi	A				FS	PHRAD	

- This procedure code would pay based on the Physician Radiology fee schedule.

Payment Type - No – Line item denied based on CT policy.

- Example: Procedure code 61796 “Srs cranial lesion simple”, payment type “No”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
61796	Srs cranial lesion simple	B				No		
61797	Srs cran les simple addl	B				No		

CMAP Addendum B

Status Indicator N – Packaged

- Line item details that return a “N” status indicator will be packaged, because the reimbursement for these items and/or services are included in the APC payment for another detail on the same date.
- The cost of the packaged services are allocated to the APC but are not paid separately. Some examples of packaged items are:
 - ancillary services;
 - implantable medical devices;
 - most clinical diagnostic laboratory tests; and
 - recovery room use.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
A4206	1 cc sterile syringe&needle	N				APC		

CMAP Addendum B

CMAP Addendum B - Legend Tab

Field Label	Field Description	Valid Values
Procedure Code	Five digit CPT or HCPCS code.	See CPT or HCPCS manual.
Short Descriptor	Short description for the procedure code field.	See CPT or HCPCS manual.
Status Indicator	The status indicator assigned by CMS. If the Payment Type value is APC, the status indicator will process according to CMS/Medicare guidelines.	See Medicare Addendum D1. * - Procedure code corrections added 1/22/2018 by CMS. SI values not yet available.
APC ¹	The APC group assigned by CMS for that procedure code.	See Medicare Addendum B for APC group and Medicare Addendum A for APC descriptions.
Relative Weight ¹	The relative weight assigned by CMS for the APC group assigned.	See Medicare Addendum A or Addendum B.
Payment Rate ¹	For procedure codes with a payment type of APC-PR and PR this field is the rate that the procedure code will be reimbursed. For procedure codes with payment type of SURG, this field indicates MP for manual priced or the rate the procedure code will be reimbursed.	
Payment Type	Identifies the payment method used by DSS to determine if and how the procedure code will be reimbursed.	APC — Reimbursed using APC methodology. APC-FS — APC (packaged) except a claim for a 'non-patient', then reimbursed based on the Lab fee schedule. APC-PR — APC reimbursed based on payment rate. FS — Reimbursed based on the CT fee schedule listed in the CT Fee Schedule field. FS-CMAP — Reimbursed based on the CT fee schedule listed in CT Fee Schedule field. These codes are not on Medicare's version of Addendum B. MP — Manually priced. No — Not covered by CT Medicaid (payment denied). NP — Service only reimbursed when non-patient and will pay off LAB fee schedule. PR — Reimbursed based on amount in Payment Rate field. RCC — Reimbursed based on revenue center code pricing.

CMAP Addendum B

CMAP Addendum B - Legend Tab Cont.

CT Fee Schedule	Identifies which fee schedule will be utilized for a given procedure code. Field is blank if service will not be paid using a fee schedule.	See CT Fee Schedule Legend.
Change	This field is only present on the Changes tab and indicates whether it is a changed or a new record. Discontinued codes have been removed.	<p>New - The procedure code was added by CMS.</p> <p>G K - The procedure code has a status indicator G or K rate change.</p> <p>X - A change has been made to the procedure code or status indicator.</p> <p>Blank - No change</p>

CMAP Addendum B - CT Fee Schedule Legend Tab

Fee Schedule Label	Fee Schedule Description
Clinic/OP - BH if RCC = 900	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 900. All other instances are not covered.
Clinic/OP - BH if RCC = 905	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 905. All other instances are not covered.
Clinic/OP - BH if RCC = 906	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 906. All other instances are not covered.
Clinic/OP - BH if RCC = 907	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 907. All other instances are not covered.
Clinic/OP - BH if RCC = 913	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 913. All other instances are not covered.
Clinic/OP - BH if RCC = 914	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 914. All other instances are not covered.
Clinic/OP - BH if RCC = 915	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 915. All other instances are not covered.
Clinic/OP - BH if RCC = 916	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 916. All other instances are not covered.
Clinic/OP - BH if RCC = 918	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 918. All other instances are not covered.
Clinic/OP - BH if RCC = 919	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 919. All other instances are not covered.

CMAP Addendum B

CMAP Addendum B - CT Fee Schedule Legend Tab Cont.

FP/OFOUT	For 340B providers use the Clinic-Family Planning fee schedule. For all others providers use the Physician Office and Outpatient fee schedule.
LAB	Lab fee schedule.
MEDS - DME	MEDS-DME fee schedule.
MEDS - Hearing Aid	MEDS-Hearing Aid/Prosthetic Eye fee schedule.
NDCLOW	Reimbursed based on the lower of Estimated Acquisition Cost (EAC), Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) for the NDC and units.
OFOUT	Physician Office and Outpatient fee schedule.
PHRAD	Physician Radiology fee schedule.
RCC 401	The procedure code must be billed with RCC 401 and will be reimbursed based on the rate on file for RCC 401 on the hospital outpatient flat fee schedule.
RCC 403	The procedure code must be billed with RCC 403 and will be reimbursed based on the rate on file for RCC 403 on the hospital outpatient flat fee schedule.
RCC 771	The procedure code must be billed with RCC 771 and will be reimbursed based on the rate on file for RCC 771 on the hospital outpatient flat fee schedule.
RCC 901	The procedure code must be billed with RCC 901 and will be reimbursed based on the rate on file for RCC 901 on the hospital outpatient flat fee schedule.
RCC 953	The procedure code must be billed with RCC 953 and will be reimbursed based on the rate on file for RCC 953 on the hospital outpatient flat fee schedule.
Therapy RCC	The procedure code must be billed with one of the appropriate therapy RCCs and will be reimbursed based on the rate on file for the RCC on the hospital outpatient flat fee schedule. (421,424,431,434,441,444)

Provider Fee Schedule

To view the hospital's fee schedule, from the Web site www.ctdssmap.com go to "Provider", then to "Provider Fee Schedule Download", then scroll down and click on "I Accept", then depending on the services you performed based on CMAP Addendum B and click on the CSV link.

Home Information **Provider** Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search **provider fee schedule download**
promoting interoperability program oos instructions/information fingerprint criminal background check info e-mail subscription secure site

***** Click here for the Fee Schedule Instructions *****

Provider Fee Schedule Download

- Acquired Brain Injury Case Management [CSV](#)
- Acquired Brain Injury DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Fiduciary [CSV](#)
- Acquired Brain Injury II DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Service Provider [CSV](#)
- Ambulatory Detoxification [CSV](#)
- Autism Spectrum Disorder [CSV](#)
- Autism Waiver Fiscal Intermediary [CSV](#)
- Autism Waiver Service Provider [CSV](#)
- Behavioral Health Clinician [CSV](#)
- Chiropractor [CSV](#)
- Clinic - Ambulatory Surgical Center [CSV](#)
- Clinic - Chemical Maintenance [CSV](#)
- Clinic - Clinic and Outpatient Hospital Behavioral Health [CSV](#)

Quick Link

- [Fee Schedule Quick Start](#)

Email Subscription

- [Register/Update Email Subscription](#)

Provider Fee Schedule

- Hospital DRG Organ Acquisition [PDF](#)
- Hospital Outpatient Flat Fee [CSV](#)
- Independent Audiology and Speech and Language Pathology [CSV](#)
- Independent Physical Therapy and Occupational Therapy [CSV](#)
- Independent Radiology [CSV](#)
- Lab [CSV](#)
- MEDS - DME [CSV](#)
- MEDS-Hearing Aid/Prosthetic Eye [CSV](#)
- MEDS-Medical/Surgical Supplies [CSV](#)
- MEDS-MISC [CSV](#)
- MEDS-Parenteral-Enteral [CSV](#)
- MEDS-Prosthetic/Orthotic [CSV](#)
- Mental Health Waiver [CSV](#)
- Natureopath [PDF](#)
- Optician/Eyeglasses [CSV](#)
- Personal Care Assistant [CSV](#)
- Physician Anesthesia [CSV](#)
- Physician Office and Outpt Services [CSV](#)
- Physician Radiology [CSV](#)
- Physician Surgical [CSV](#)
- Psychologist [CSV](#)
- Special Services [CSV](#)
- Special Services-Birth to Three Yrs [CSV](#)
- Target Case Management Non-Contracted [CSV](#)
- Transportation - Air Ambulance [CSV](#)
- Transportation - Basic/Advanced [CSV](#)
- Transportation - Critical Helicopter [CSV](#)
- Transportation - Non-emergency Medical [CSV](#)
- Transportation - Travel Agent [CSV](#)

[Click here for the Historical Behavioral Health Fee Schedules](#)

[Hospital - Click here for the current CMAP Addendum B](#)

[Hospital - Click here for the Historical CMAP Addendum B](#)

Provider Fee Schedule

Clinic and Outpatient Hospital Behavioral Health								

Please contact CT BHP at 1-877-552-8247 for all Prior Authorizations								

T1015 may be billed only by FQHC and has a provider specific rate								

Providers must have a Day Treatment or Day and Evening Treatment license from DPH in order to provide and bill Day Treatment or Day/Evening Treatment (H2013). Providers must be certified by CMS as a CMHC in order to provide and bill for PHP (H0035). Providers must have an Extended Day Treatment (EDT) license from DCF in order to provide and bill for EDT (H2012). Providers must have an EMPS certification from DCF to provide and bill for EMPS (S9484 or S9485); and have certification for specific home based services from DCF in order to provide and bill for home based services (H2019 or T1017).								

Procedure	Proc description	Mod1	Mod1 desc	Rate Type	Max Fee	Effective	End Date	PA
90785	Psytx complex interactive			ECC	14.95	7/1/2015	12/31/2299	Y
90785	Psytx complex interactive			MMH	11.26	7/1/2015	12/31/2299	Y
90785	Psytx complex interactive			OEC	14.95	7/1/2016	12/31/2299	Y
90785	Psytx complex interactive			OMH	11.26	7/1/2016	12/31/2299	Y
90791	Psych diagnostic evaluation			ECC	140.1	7/1/2015	12/31/2299	Y
90791	Psych diagnostic evaluation			MMH	133.1	7/1/2015	12/31/2299	Y
90791	Psych diagnostic evaluation			OEC	140.1	7/1/2016	12/31/2299	Y
90791	Psych diagnostic evaluation			OMH	133.1	7/1/2016	12/31/2299	Y
90791	Psych diagnostic evaluation	U5	Autism Services	ECC	612	1/1/2019	12/31/2299	Y
90791	Psych diagnostic evaluation	U5	Autism Services	MMH	612	1/1/2019	12/31/2299	Y
90792	Psych diag eval w/med srvcs			ECC	150.87	7/1/2015	12/31/2299	Y
90792	Psych diag eval w/med srvcs			MMH	143.33	7/1/2015	12/31/2299	Y
90792	Psych diag eval w/med srvcs			OEC	150.87	7/1/2016	12/31/2299	Y
90792	Psych diag eval w/med srvcs			OMH	143.33	7/1/2016	12/31/2299	Y

- OEC and OMH rate types are only payable for Outpatient Hospital Providers.
- U5 – Autism Services

Provider Fee Schedule

Hospital Outpatient Flat Fee Schedule					
RCC Code	RCC description	Rate Type	Amount	Effective Date	End Date
401	DIAGNOSTIC MAMMAGRAPHY	DEF	148.61	7/1/2016	12/31/2299
401	DIAGNOSTIC MAMMAGRAPHY	RCC	151.88	1/1/2020	12/31/2299
403	SCREENING MAMMAGRAPHY	DEF	117.91	7/1/2016	12/31/2299
403	SCREENING MAMMAGRAPHY	RCC	120.5	1/1/2020	12/31/2299
421	PHYS THERP/VISIT	DEF	83.98	7/1/2016	12/31/2299
421	PHYS THERP/VISIT	RCC	85.83	1/1/2020	12/31/2299
431	OCCUP THERP/VISIT	DEF	97.24	7/1/2016	12/31/2299
431	OCCUP THERP/VISIT	RCC	99.38	1/1/2020	12/31/2299
441	SPEECH PATH/VISIT	DEF	106.08	7/1/2016	12/31/2299
441	SPEECH PATH/VISIT	RCC	108.41	1/1/2020	12/31/2299
771	VACCINE ADMINISTRATION	DEF	2	7/1/2016	12/31/2299
771	VACCINE ADMINISTRATION	RCC	2.04	1/1/2020	12/31/2299
RCC 769 is a hospital specific rate for hospitals approved to provide services for CARES (Child and Adolescent Rapid Emergency Stabilization)					
Rate type DEF is nongovernmental licensed short-term general hospitals located in the state					
Rate type RCC is all hospitals other than DEF (governmental licensed short-term general; children's; chronic disease; psychiatric; out-of-state and border hospitals)					

- DEF – Nongovernmental licensed short-term general hospitals.
- RCC – All other hospitals other than DEF.

APR DRG

Inpatient Hospital claims are processed based on the Diagnostic Related Group (DRG) returned from the All Patient Refined-Diagnostic Related Group (APR DRG) grouper.

- 3M Health Information Systems has made a tool available to the hospitals to determine the APR DRG based on input of several data elements on the inpatient claim to determine the DRG code that will be used to price the claim.
 - The tool is available on the Web site www.aprdrgassign.com.
- In order to access this Web site, users will be required to enter a User ID and Password. To obtain this User ID and Password, please send a request via e-mail to ctxihospay@dx.com.

APR DRG

3M Health Information Systems

- Once you receive the User ID and Password, you will need to read the terms and conditions, enter the User ID and Password and accept the agreement to log into the site.

Please input your username and password to continue

Username: *

Password: *

- Then click on the APR DRG Assignment Report.

3M Worldwide : United States : Health Care
Welcome CTHosp

▼ 3M™ All-Patient Refined Web Portal

- APR DRG Assignment Report

↑

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3M Health Information Systems

Welcome to 3M™ All-Patient Refined Web Portal

All Patient Refined DRGs

APR DRG

3M Health Information Systems

3M Worldwide : United States : Health Care
Welcome CTHosp

- Portal Home
- ▼ 3M™ APR Assignment Report for the Web
 - Definitions Manual
 - Methodology Overview
 - APR Calculator
 - Web Release Notes

Welcome to 3M™ APR Assignment Report for the Web

The 3M APR Assignment Report provides an in depth explanation of how each of the 18 steps in the APR DRG Severity of Illness and Risk of Mortality assignment logic is applied to a specific patient. The report is extremely useful for understanding why an individual patient was assigned to a specific SOI and ROM level. It can assist in understanding the methodology and can be used as a teaching tool to achieve comprehensive coding for accurate 3M APR DRG assignment. The report can dynamically visualize the information found in the Definitions manual.

- Click on APR Calculator.

APR DRG

3M Health Information Systems

- Data Entry Tab - Demographics

Data Entry **Output Report** **Help**

Grouper Version

Demographics **Codes**

Grouping type: Discharge DRG (excludes Complication of Care codes)
 Admission/Discharge DRG (excludes non-POA Complication of Care codes)

Case ID

Birth weight option

Sex

Birth Weight (Grams)

Discharge status

Days on Mech. Vent.

Admission Age

Discharge Age (days)

Days
 Years

APR DRG

3M Health Information Systems

- Data Entry Tab – Demographics
1. Grouper Version – Select from drop down “APR DRG Grouper” v37.1 (04/01/20) ICD-10
 2. Grouping Type – There are two options for the grouping type: Discharge DRG and Admission/Discharge DRG. The grouping type determines if the report will include both Admission and Discharge information, or just Discharge information.
 - Select: Admission/Discharge DRG (Excludes non-POA Complication of Care codes).
 3. Sex – Select Male, Female, or Unknown.

APR DRG

4. Discharge Status – Select the patient status on the claim from the drop down selection.
5. Admission Age – Enter the age of the client at the time of admission in days or years.
6. Admission Date and Discharge Date – Enter the date of admission and discharge date of the inpatient stay.
7. Birth Weight Option* – Select 7 “Entered or coded w/default, X-chk”.
8. Birth Weight (Grams)* – Enter weight of newborn in grams.

*Fields 7 and 8 only needs to be filled in if you are trying to determine the DRG code on a newborn claims.

APR DRG

3M Health Information Systems - Data Entry Tab – Codes

- Diagnoses

The screenshot displays the 'Diagnoses List' interface within the 3M Health Information Systems. The interface includes a navigation bar with 'Data Entry', 'Output Report', and 'Help' tabs. The 'Grouper Version' is set to 'APR DRG Grouper v31.0 (10/01/13) ICD-9'. The 'Diagnoses' tab is selected, and the 'Diagnoses List' table is visible. The table has four columns: '#', 'Diagnosis Code', 'Description', and 'Present On Admission'. The first row is labeled 'PDX'. Two blue arrows point to the 'Diagnosis Code' and 'Present On Admission' fields of the first row. The table has 9 rows. Below the table is a 'Clear Diagnoses' button.

#	Diagnosis Code	Description	Present On Admission
PDX			Y-Yes
1			Y-Yes
2			Y-Yes
3			Y-Yes
4			Y-Yes
5			Y-Yes
6			Y-Yes
7			Y-Yes
8			Y-Yes
9			Y-Yes

Page: 1 of 5 Go

Clear Diagnoses

- Enter the diagnosis on the claim beginning with the Principal Diagnosis (PDX).
- Enter the corresponding Present on Admission (POA) indicator for each diagnosis.

APR DRG

3M Health Information Systems - Data Entry Tab – Codes

- Procedure codes and procedure dates.

Data Entry Output Report Help

Grouper Version APR DRG Grouper v31.0 (10/01/13) ICD-9

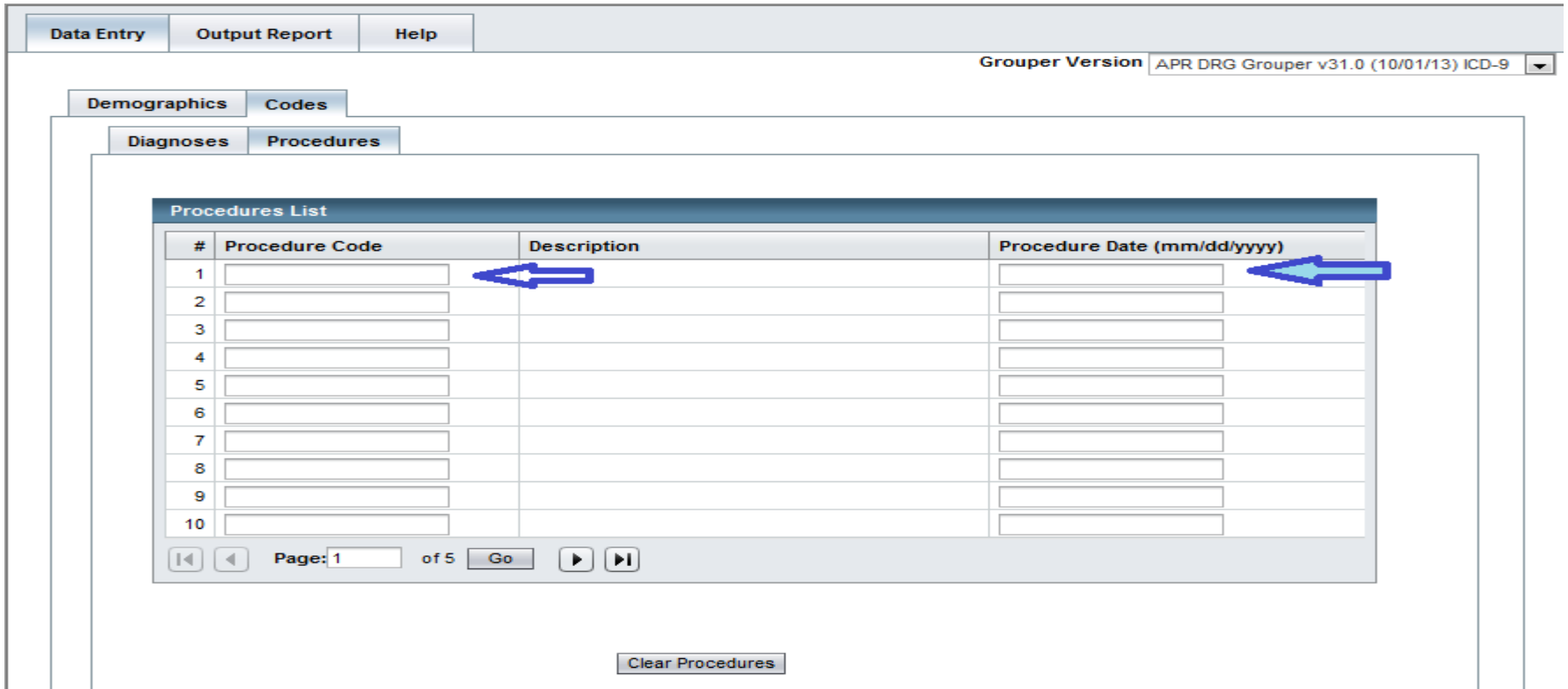
Demographics Codes

Diagnoses Procedures

#	Procedure Code	Description	Procedure Date (mm/dd/yyyy)
1	<input type="text"/>		<input type="text"/>
2	<input type="text"/>		<input type="text"/>
3	<input type="text"/>		<input type="text"/>
4	<input type="text"/>		<input type="text"/>
5	<input type="text"/>		<input type="text"/>
6	<input type="text"/>		<input type="text"/>
7	<input type="text"/>		<input type="text"/>
8	<input type="text"/>		<input type="text"/>
9	<input type="text"/>		<input type="text"/>
10	<input type="text"/>		<input type="text"/>

Page: 1 of 5 Go < >

Clear Procedures



APR DRG

3M Health Information Systems – Output Report



- Once all information has been entered, under the “Output Report” tab, click on “Download Report” to get the report on your request which will include the APR DRG and Severity of Illness (SOI) code for the inpatient stay.

APR DRG

3M Health Information Systems – Output Report

- Output Report – Identifying DRG and SOI code as 204-1. The inpatient claim will process based on DRG code 2041

3M Health Information Systems

3M™ APR DRG Assignment Report

APR DRG Version 37.1

Codes FY 2020 ICD-10

Patient ID : *Not entered*

Age in Years : 30

Days Mech Vent (DMV) :

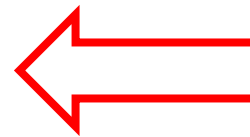
Sex : Male

Status : 1 - Home - Self-care (Routine)

DMV Source : 6 - No DMV

Grouper Results for Admission APR DRG

MDC:	5 - CIRCULATORY SYSTEM
All Patient Refined DRG :	204 - SYNCOPE & COLLAPSE
Severity of Illness :	1 - Minor Patient Severity of Illness
Risk of Mortality :	1 - Minor Patient Risk of Mortality
Medical/Surgical DRG :	Medical
Return Code :	0 - DRG assigned



Hospital Modernization - DRG

DRG Calculator

Once the 3M tool sets a DRG code 2041, the hospitals can use the interactive DRG calculator to see what the DRG payment amount is on their inpatient claim.

- The interactive DRG calculator is available on the hospital modernization page on the www.ctdssmap.com Web page.
- If the 3M tool returns with DRG code 956 “Ungroupable”, it means the DRG could not be determined based on the information on the inpatient claim.
 - The inpatient claim will deny with EOB code 0691 “DRG – Ungroupable”.

If the hospital is questioning the DRG code or payment on their inpatient claim they can e-mail their questions to the Hospital Modernization APR or DRG questions e-mail address ctxihospipay@dxc.com with a screen shot of the results from the 3M tool or DRG calculator.

Hospital Modernization - DRG

Connecticut Medical Assistance Program APR DRG Pricing Calculator

Effective for Discharges 1/1/2020 and Forward

Indicates data to be input
by the user

Information	Data	Comments or Formula
INFORMATION FROM THE CLAIM		
Submitted charges	\$22,500.00	UB 04 Field Locator 47.
Non-covered charges	\$0.00	UB 04 Field Locator 48. For the purposes of calculating the outlier add-on payment, the non-covered charges must include a reduction for HCAC related charges.
Length of stay	4	Used for transfer pricing and non-covered days adjustments.
Client eligible days	4	Used for non-covered days adjustment.
Was patient transferred with discharge status = 02 or 05?	No	Used for transfer pricing adjustment.
Organ acquisition costs	\$0.00	UB 04 Field Locator 47 for RCC 81X used for calculating outlier add-on.
Practitioner costs	\$0.00	UB 04 Field Locator 47 for RCC 96X, 97X and 98X used for calculating outlier add-on.
Observation over 72 hours	\$0.00	UB 04 Field Location 47 for RCC 762 use for calculating outlier add-on.
Third Party Liability	\$0.00	UB 04 Field Locator 54 for payments by third parties.
Provider AVRS ID	008055460	Select AVRS ID. Out of state and border status hospitals should select AVRS ID 008055460.
Provider name	Out of State/Border Status Hospital	Look up from Provider table.
APR DRG INFORMATION		
APR DRG	2041	From 3M-PC software version 37.
APR DRG description	Syncope & Collapse	Look up from DRG table.
APR DRG weight	0.4867	Look up from DRG table.
Average length of stay for this APR DRG	1.89	Look up from DRG table.
HOSPITAL INFORMATION		
Hospital Adjusted base rate	\$9,704.84	Look up from Provider table. The hospital Adjusted base rate is used to determine APR DRG base payment.
Hospital cost-to-charge ratio	0.32964	Look up from Provider table. Hospital cost-to-charge ratio used to estimate the hospital's cost of this stay in order to determine outlier add-on.
PAYMENT POLICY PARAMETERS SET BY DSS		
DRG outlier threshold	\$30,000.00	Look up from DRG table.
Outlier payment percentage	75%	Used for cost outlier adjustments.



Hospital Modernization - DRG

DRG Calculator

- Each field is defined under the Calculator Instructions, but the fields highlighted in green are required to be entered by the user.
 - Submitted Charges – UB-04 field locator 47.
 - Non-covered Charges – UB-04 field locator 48. This would include charges for non-covered days.
 - Length of Stay – This is used in pricing transfer stays or partial eligibility.
 - The length of stay equals discharge date minus admit date, unless the discharge date equals the admit date, in which case length of stay is 1.
 - ❖ Inpatient stay admitted on May 1, 2020 and discharged on May 11, 2020, the hospital would enter 10.

Hospital Modernization - DRG

DRG Calculator

- If the stay is for a transfer claim, the length of stay will equal discharge date minus admit date plus one day.
 - ❖ Inpatient stay admitted on May 1, 2020 and transferred on May 11, 2020 the hospital would enter 11.

- Client Eligible Days – Used for non-covered days adjustments. Enter the number of days the client is eligible during the stay, In most cases this will equal the full length of stay including transfer claims.

- Was patient transferred with discharge status = 02 or 05? - Enter Yes or No from the drop down box.

- Organ Acquisition Costs – If billing RCC 810-812, enter billed amount.

- Practitioners Costs – If the hospital bills 96X, 97X, 98X on the institutional claims instead of CMS-1500 the service will be denied on the claim and the hospital needs to enter the billed amount in this field.

Hospital Modernization - DRG

DRG Calculator

- Observation over 72 hours – RCC 762 enter amount billed for charges over 72 hours.

- Third Party Liability (TPL) – Enter TPL payment.

- Provider AVRS ID – Select AVRS ID based on drop down list.
 - Provider Name – Auto-populated
 - Hospital Base Rate – Auto-populated
 - Hospital cost-to-charge ratio – Auto-populated

Once you entered all the information, the DRG pricing calculator will estimate the APR DRG allowed amount (E45) and payment amount (E48).

Hospital Modernization - DRG

DRG Calculator

Example – Inpatient stay admitted on May 1, 2020 and discharged on May 11, 2020 with a discharge status 01 for a female client 34 years old. Total charges \$22,500, APR DRG 2041, APR DRG weight 0.4867, Average Length of Stay (ALOS) of 1.89, and DRG Outlier Threshold of \$30,000.00. The Hospital base rate is \$9,704.84 and Hospital cost-to-charge ratio is 0.32964.

- APR DRG weight, ALOS and DRG Outlier Threshold amounts are found under the DRG Table CT on the DRG Pricing Calculator.
- DRG Table CT - The "DRG Table CT" is the final tab under the DRG calculator that contains a list of the APR DRG codes and parameters used in pricing individual hospital inpatient stays. APR DRG codes, descriptions, national relative weights, and Average Lengths of Stay (ALOS) are determined by 3M Health Information Systems. The DRG Outlier Thresholds were developed specifically for CT through a rate setting process.

Hospital Modernization - DRG

DRG Calculator

- APR DRG 2041

Connecticut Department of Social Services - Division of Health Services Inpatient DRGs

Weights and Outlier Thresholds Under APR-DRG V37 Effective for Discharges 1/1/2020 and Forward

This spreadsheet includes data obtained through the use of proprietary computer software created, owned and licensed by the 3M Company.

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DRG	MDC	Description	Weight	ALOS	Outlier Threshold	Beginning Date	
2041	05	Syncope & Collapse	0.4867	1.89	30,000.00	1/1/2020	12/31/2299
2042	05	Syncope & Collapse	0.5364	2.32	30,000.00	1/1/2020	12/31/2299
2043	05	Syncope & Collapse	0.6627	3.11	35,951.08	1/1/2020	12/31/2299
2044	05	Syncope & Collapse	1.1471	4.63	80,734.69	1/1/2020	12/31/2299



Hospital Modernization - DRG

Connecticut Medical Assistance Program APR DRG Pricing Calculator

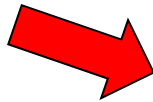
Effective for Discharges 1/1/2020 and Forward

Indicates data to be input
by the user

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Was patient transferred with discharge status = 02 or 05?	No	Used for transfer pricing adjustment.
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Hospital cost-to-charge ratio	0.32964	Look up from Provider table. Hospital cost-to-charge ratio used to estimate the hospital's cost of this stay in order to determine outlier add-on.
PAYMENT POLICY PARAMETERS SET BY DSS		
DRG outlier threshold	\$30,000.00	Look up from DRG table.
Outlier payment percentage	75%	Used for cost outlier adjustments.

Hospital Modernization - DRG

APR DRG BASE PAYMENT		
Pre-transfer APR DRG base payment	\$4,723.35	E24*E21
TRANSFER PAYMENT ADJUSTMENT		
Is a transfer adjustment potentially applicable?	No	E11
Transfer base payment	N/A	IF(E32="Yes", (E30/E22)*(E9+1), else "N/A")
Is transfer base payment < pre-transfer base payment?	N/A	IF(E32="Yes", IF(E33<E30, "Yes", else "No"), else "N/A")
Full Stay APR DRG base payment	\$4,723.35	IF(E34="Yes", E33, else E30)
OUTLIER ADD-ON DETERMINATION		
Hospital specific estimated cost of the stay	\$8,241.00	(E7-E8-E12-E13-E14) * E24
Does this claim require an outlier payment?	No	IF E27 > E37 "No", Else "Yes"
Cost outlier payment	\$0.00	IF E38 = "Yes" (E37 - E27) * E28, Else 0
NON-COVERED PAYMENT ADJUSTMENT		
Are covered days less than length of stay	No	IF E10 < E9 "Yes", Else "No"
Non-covered day reduction factor	1.000000	IF E41 = "Yes", (E10/E9) Else 1.0
Non-covered adjusted APR DRG base payment	\$4,723.35	IF E41 = "Yes", IF(E32="Yes", (E30/E22)*(E10+1), ((E10/E9)*E30)) else E35
Non-covered adjusted outlier payment	\$0.00	E39 * E42
CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT		
APR DRG allowed amount	\$4,723.35	IF(E43>E30, E30+E44, E43+E44)
Does the charge cap apply?	No	IF E46 > E7 "Yes", Else "No"
Third Party Liability	\$0.00	E15
Payment amount	\$4,723.35	IF E46="Yes", then (E7-E47), Else (E45-E47) This will not include payment made for organ acquisition which is paid outside of the DRG payment methodology
CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.		



Payment Amount is \$4,723.35. (The hospital claim payment will not exceed the total billed amount of the claim)

- **EOB code 8600 “Reimbursed via DRG Pricing” will post to claims that pay at DRG pricing.**

Hospital Inpatient Services

Pediatric Discharge Delay

- A medically necessary discharge delay (DCD) status begins on the day that the member is determined to be clinically capable of transitioning to the next appropriate level of care; however, that level of care is not available, and the member cannot otherwise be discharged from an acute care inpatient setting for HUSKY Health members under the age of 19.
- The DCD rate is considered an all-inclusive daily rate; therefore, professional behavioral health services cannot be billed separately. Behavioral health treatment services must continually be provided while the child remains in the DCD status. The hospital is eligible for the DCD reimbursement in conjunction with the inpatient All Patient Refined - Diagnostic Related Group (DRG) reimbursement.
- The BH discharge delay days must be billed under Revenue Center Code (RCC) 224 “Late Discharge / Medically Necessary.”

Hospital Inpatient Services

Pediatric Discharge Delay

- If a CMAP member's primary reason for an inpatient admission is behavioral health in nature, prior authorization (PA) for that admission must be obtained from CMAP's behavioral health administrative service organization (ASO), Beacon Health Options.
- If a medically necessary DCD stay is required, the hospital must contact Beacon Health Options to obtain PA for the DCD stay. There will not be separate PA provided for the DCD stay; the acute care days and the discharge delay days will be included under a single PA number, but distinguished by the dates covered as either acute care days or discharge delay days.
- Acute Care days are identified by revenue code list 13 on a Beacon health PA.
- DCDs are identified by revenue code list 2039.

Hospital Inpatient Services

Pediatric Discharge Delay

Line Item																
Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	Revenue Code	Revenue Code List	Drug Name	
01	4.000	\$0.00	4.000	\$0.00	Approved									13		
02	7.000	\$0.00	7.000	\$0.00	Approved								2039			

Type changes below.

Line Item: 02

Service Type Code* [Search]

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search]

Proc/Mod List

Procedure Code List

Requested Eff./End Dates*

Requested Units/Dollars*

Drug Name

Status

Authorized Units/Dollars

Authorized Eff./End Dates

Used Units/Dollars

Available Units/Dollars

Frequency

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

Regulations / Policies

Provider Manuals

The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission. The provider manual contains detailed instructions regarding CMAP, and should be your first source of information pertaining to policy and procedural questions.

- The Provider Manual is divided into twelve (12) chapters.
 - Click on the chapter title to open the document (disable pop-up blockers).
 - Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click View Chapter to access the chapter.

The provider manual is available on the www.ctdssmap.com Web site from the Publications page.

Regulations / Policies

Provider Manuals	
Chapter	Title
1	Introduction
2	Provider Participation Policy
3	Provider Enrollment and Re-enrollment
4	Client Eligibility
5	Claim Submission Information Additional Chapter 5 Information <ul style="list-style-type: none"> • Carrier Listing Sorted by Name • Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
7	Specific Policy / Regulation Hospital Inpatient: NEW Requirements Eff. 1-1-15 ▾ View Chapter 7
8	Provider Specific Claims Submission Instructions Hospital ▾ View Chapter 8
9	Prior Authorization
10	Web Portal/AVRS
11	Other Insurance and Medicare Billing Guides Select a claim type ▾ View Chapter 11
12	Claim Resolution Guide

Regulations / Policies

- Chapter 1 – Introduction
 - Provides an overview on the CT Medical Assistance Program, the Department of Social Services' and DXC Technology's responsibilities and resources.
- Chapter 2 – Provider Participation Regulations
 - Details the CMAP regulations for provider participation.

Examples:

- Accept as payment in full either the Department's payment or a combination of Department, third party payment, and any authorized client copayment which is no more than the Department's schedule of payment, except with regard to the Department's obligations for payment of Medicare coinsurance and deductibles.
- The Department shall not pay for cancelled office visits and appointments not kept.

Regulations / Policies

- Chapter 5 - Claim Submission Information
 - Chapter 5 contains the general claim submission information, claim related correspondence, behavioral health program guidelines, Remittance Advice (RA), electronic funds transfer, Medicare/insurance carrier information and program forms applicable to most providers participating in the Connecticut Medical Assistance Program.
 - Timely filing guidelines are one (1) year from the actual date of service.
 - Exceptions are listed in the section titled exceptions to the timely filing limit.
 - Correcting or updating Third Party Liability (TPL) information is located in this chapter.
- Chapter 7 – Specific Policy / Regulation
 - This chapter contains medical services policies that pertain to providers. Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act.
 - This chapter is separated by provider type.

Regulations / Policies

- Provider Manual Chapter 8 - Provider Specific Claims Submission Instructions are located on the www.ctdssmap.com Web site; under Publications, scroll to Provider Manual Chapter 8 and from the drop down select the provider type.
- Provider Manual Chapter 11 - Other Insurance and Medicare billing guide is located on the www.ctdssmap.com Web site; under Publications, scroll to Provider Manual Chapter 11 and select claim type “Professional Other Insurance/Medicare Billing Guide”.
- Provider Manual Chapter 12 – Claim Resolution Guide will provide a detailed description of the cause of each Explanation of Benefit (EOB) code and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition.
 - This guide also provides tips by identifying where providers can go to find additional information to assist with Frequent Claim Denial.

Frequent Claim Denial

EOB code 0314 “APC - Observation revenue code on line item with non-observation HCPCS code”

Cause

- An outpatient claim was submitted with RCC 762 (observation) with a HCPCS other than HCPC code G0378 “Hospital observation per hr”.

Resolution

- Please verify the procedure code submitted on the claim in connection with RCC 762. If it is incorrect, correct the claim and re-submit.

Frequent Claim Denial

EOB code 0337 “APC – Total Allowed Amount on APC Claim is Zero.”

Cause

- The outpatient claim was billed with an APC payable procedure code that was denied with a different EOB code causing there to be no APC payable allowed amount on the claim.

Resolution

- Please review the other EOB code setting on the APC payable procedure code and, once you resolve that EOB, it should resolve EOB 0337 at the same time.

Example:

- Outpatient claim denies with EOB 0337, but one of the details is also denying with EOB 0856 “Required Operating Provider Number is Missing”. If the hospital adds the operating provider number to the claim and re-submits the claim, the claim could process without denying for EOB 0337.

Frequent Claim Denial

EOB code 0878 “Allowed Amount is Zero Manual Priced Outpatient APC, Provider Fee Schedule, if Not Outpt Contact PAC.”

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.

➤ If that detail with SI “C” is not covered, it is possible the entire claim will deny.

Important Messages

- Frequently Asked Questions (FAQs) document about Telemedicine and Telphonic services and CMAP's Response to COVID-19 (Coronavirus) is located on the www.ctdssmap.com Web page on the welcome page under Important Messages.

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY DXC TECHNOLOGY ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS A WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.



Information



Provider



Trading Partner



Pharmacy

Important Messages

[Attention Hospital and Nursing Home Providers: Updated Information Regarding the PASRR Process \(Posted 4/16/20\)](#)

[COVID-19 Information and FAQs \(Updated 4/16/20\)](#)

Hospital Modernization Page

Comprehensive information on CT OPSS can be found on the “Hospital Modernization” page on the Web site www.ctdssmap.com. Please refer to this page often, as this will be continue to be updated throughout the year.

- Important Messages – Connecticut Hospital Modernization
 - Hospital Monthly Important Messages
 - Current CMAP Addendum B
 - Prior Authorization Grid for Outpatient Hospitals
 - Provider Type and Specialty to Revenue Center Code Crosswalk
- DRG Calculator
 - DRG Calculator (For Discharges Dates 1/1/2020 and Forward)
 - DRG Calculator Historical Versions

Hospital Modernization Page

- Hospital Outpatient Payment Methodology - Ambulatory Payment Classification (APC)
 - Outpatient Hospital Modernization FAQ
 - CMAP Addendum B PDF
 - CMAP Addendum B Changes and Historical Versions
- Helpful Information & Publications
 - Provider Bulletins and Policy Transmittals
 - Provider Training
 - ❖ Refresher Workshop Materials
 - Provider Manuals
 - HUSKY Health Benefit Grid (CHNCT Web site)
 - ❖ Prior Authorization
 - CT BHP Authorization Schedule (Beacon Health Options)
 - CT Provider Fee Schedule

Training Session Wrap Up

For questions please contact:

- DXC Technology Provider Assistance Center (PAC) 1-800-842-8440.

If hospitals are experiencing extended call wait times, providers 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.

- Hospital Modernization e-mail address (APC or DRG questions only) ctxixhosppay@dxc.com.

Time for Questions

Questions & Answers





Thank you.