Welcome to – Hospital Refresher Workshop Training – September 2024

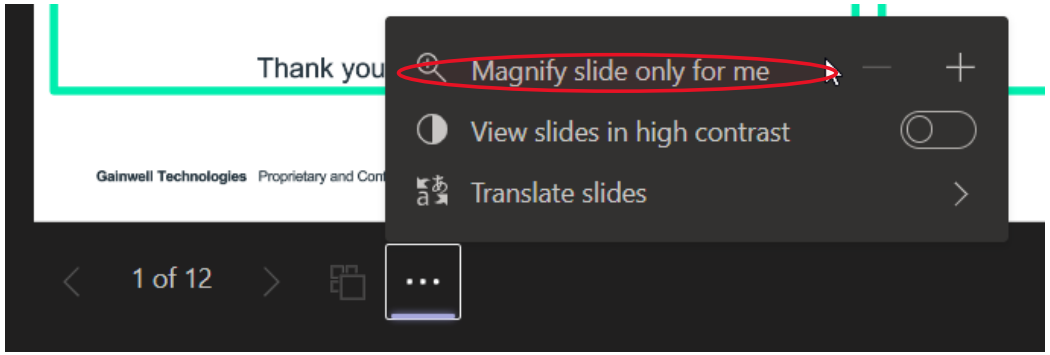
Once you have joined the Microsoft Teams meeting, please follow these communication rules:

- Please ensure your camera is off.
- Use the mute button when you are not speaking.
- Be sure to select “Show Conversation” as documents or links used during the meeting will be posted to the Meeting Chat. You may also use the meeting chat to ask the speaker a question or to comment.
- The “Raise Hand” icon or (Ctrl+Shift+K) may also be used to ask the speaker a question.

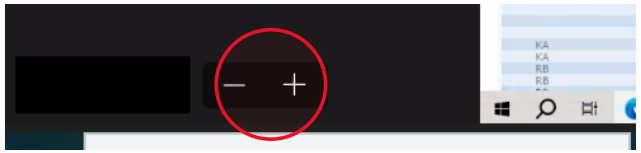
Thank you for your participation!

Troubleshooting Tips:

While content is being shared, in the lower left-hand side of the screen, click the (…) and an option to ‘Magnify slide only for me’ appears allowing you to zoom in or out.



Or it may appear with this option next to the speaker’s name, allowing you to Zoom In or Out:



Hospital Refresher Workshop

Presented by The Department of Social Services & Gainwell Technologies

September 2024

gainwell®

Agenda

- CMAP Web site and Hospital Modernization Page
- CMAP Addendum B and Provider Fee Schedule
- All Patient Refined-Diagnostic Related Group (APR DRG)
- Discharge Delay Days/Value Based Payments
- Regulations and Policies
- Frequent Claim Denials
- Resources
- Questions

CMAP Web Site

Important Messages

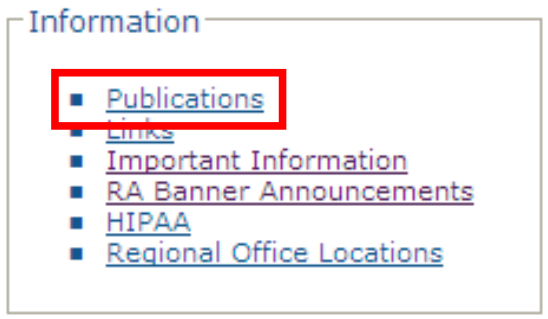
- Frequently Asked Questions (FAQs) document about COVID-19 and Telemedicine is located on the www.ctdssmap.com Web page on the welcome page under Important Messages.

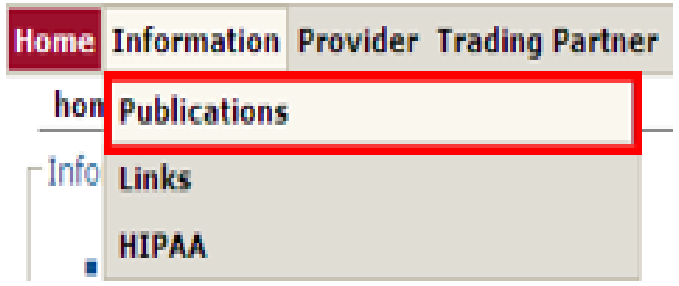
Provider Bulletins

- 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.

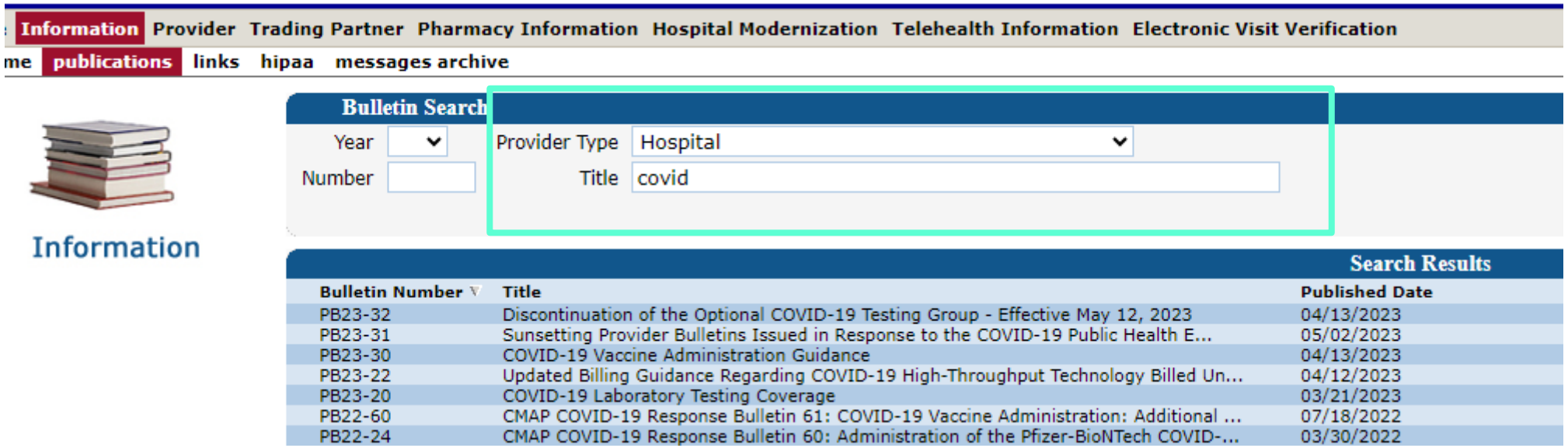




Provider Bulletins

- 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 by selecting “Hospital”. The online database of bulletins goes back to the year 2000.

  Example: Looking for all Hospital related bulletins with COVID in the title.



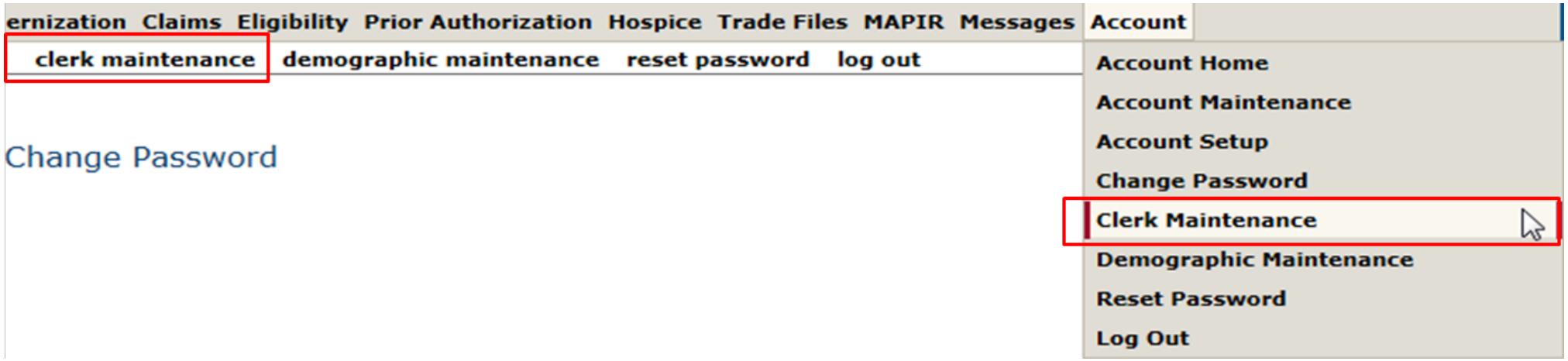
eDelivery

- The Department of Social Services (DSS) has implemented the electronic delivery of provider's letters. This is replacing the mailing of many paper letters that you currently receive from the Connecticut Medical Assistance Program (CMAP) through the United States Postal Service (USPS).
- DSS posts letters to the provider's Secure Web portal account.
- The letter(s) will be systematically posted to that user's Secure Web portal account for retrieval (E-Delivery letter retention will be approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available).
- An email notification will be sent notifying the user that a letter(s) has been posted.
- Primary Account holders have been automatically set up for E-Delivery.
- A clerk can access e-delivered letters if assigned that permission by their primary account holder.
- Please refer to PB2019-15 'Implementation of Electronic Delivery of Letters - Replacement to the Mailing of Connecticut Medical Assistance Program Letters' to sign up for your E-Delivery account for further information.

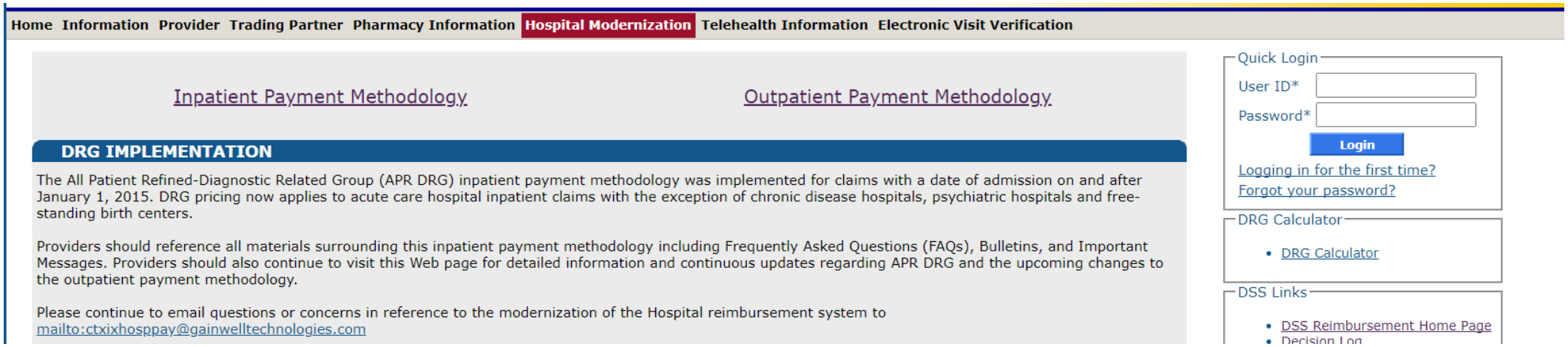
eDelivery

Clerk Maintenance

- A clerk can access E-delivered letters if assigned that permission by their primary account holder. This can be done through two roles:
  - the existing role of Trade Files (has been re-named Trade Files Includes E-Delivery) – allows access to download all files
  - a new role of Trade Files E-Delivery Only – allow access to E-Delivery letters only
- Access the Clerk Maintenance section of the Secure Site by selecting clerk maintenance from either the Account submenu or the Account drop-down menu



Hospital Modernization Page



Comprehensive information on CT OPPS 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 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

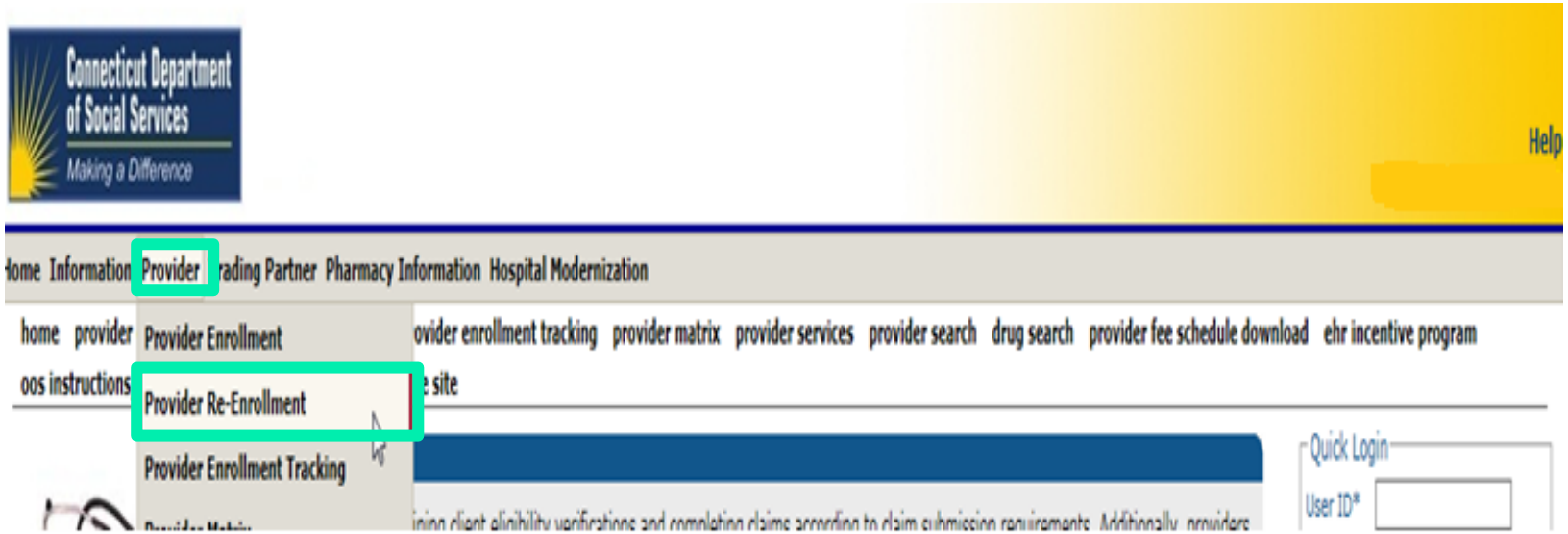
Hospital Modernization Page

- DRG Calculator
  - DRG Calculator (For Discharges Dates 1/1/2024 and Forward)
  - DRG Calculator Historical Versions
- Hospital Outpatient Payment Methodology – Ambulatory Payment Classification (APC)
  - Outpatient Hospital Modernization FAQ
  - Hospital Based Practitioners – Outpatient Services
  - CMAP Addendum B
  - CMAP Addendum B Changes and Historical Versions
- Helpful Information & Publications
  - Provider Bulletins and Policy Transmittals
  - Provider Training
    - Refresher Workshop Materials
  - FAQs
  - Provider Manuals
  - HUSKY Health Benefit Grid (CHNCT Web site)
  - CT BHP Authorization Schedule (Carelon Behavioral Health)
  - CT Provider Fee Schedule

Re-enrollments

The Department of Social Services requires providers to re-enroll online. Hospitals enroll every 2 years.

- A majority of the required information is automatically populated based on the information currently stored in the CMAP for the provider.
- Online re-enrollment cannot be initialized until an Application Tracking Number (ATN) is received from the Gainwell Technologies Provider Enrollment Unit. Letters are sent 6 months prior to the due date.
- It can take time for an enrollment to be completed. If it is not completed by the due date, claims will not be paid.



Providers with Secure Web portal access can view their re-enrollment due date on the Home page of their Secure Web portal once logged in! This enhancement allows providers to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

Re-enrollments

- **It is imperative that providers successfully complete the re-enrollment application as quickly as possible upon receipt of their notice.**
- **Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from CMAP.**
- Providers who are dis-enrolled will not be able to do the following until re-enrollment is completed:
  - Receive Prior Authorization
  - Bill or receive payment for services rendered
- Reinstatement of contracts w/out a finalized application violates ACA policies
- Re-enrollment due dates published monthly in the Hospital Important Message:

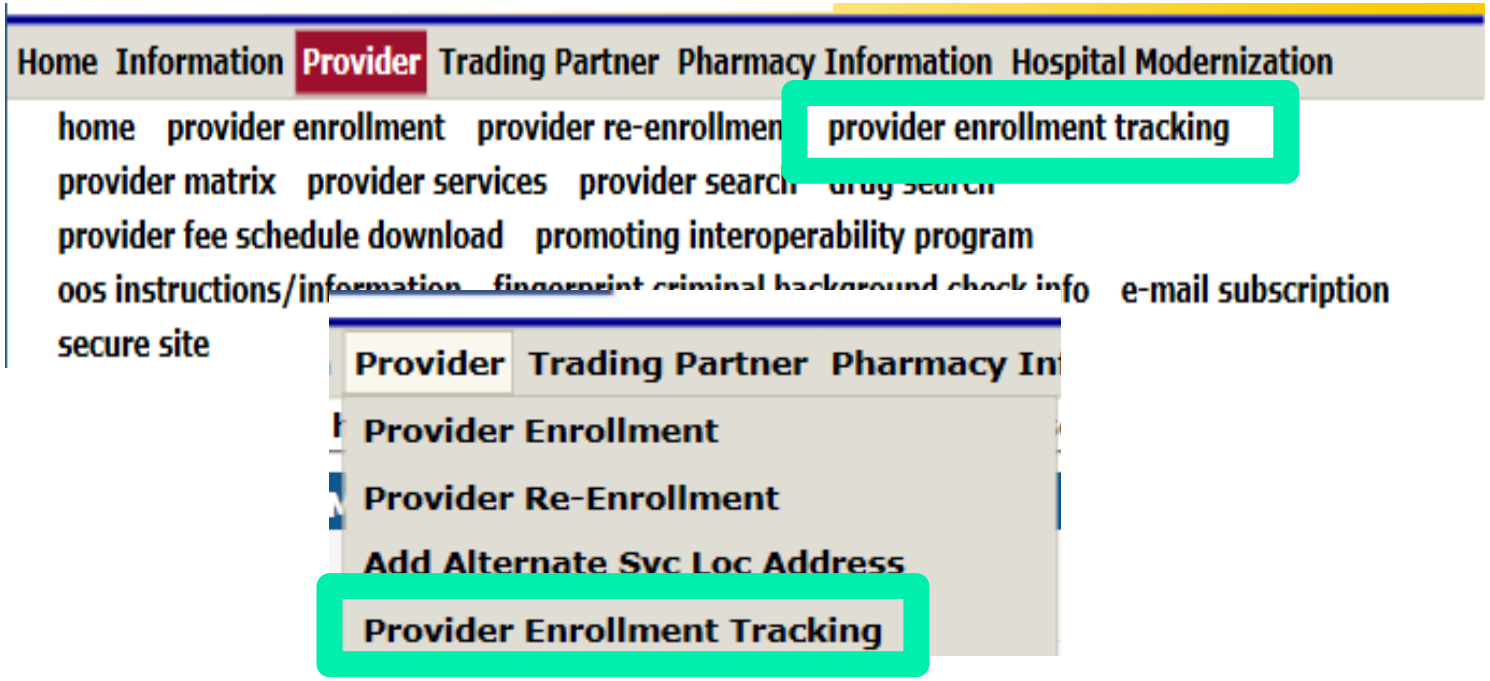
Danbury Hospital – Inpatient – 10/3/24	SVMC Holdings, Inc – Inpatient – 12/27/24
Danbury Hospital DBA New Milford Hospital – Outpatient - 10/3/24	SVMC Holdings, Inc – Intermediate Duration – 12/27/24
ST Francis Hospital and Medical Center – Dental - 10/24/24	SVMC Holdings, Inc – Inpatient – 12/27/24
ST Mary's Hospital Inc – Outpatient - 11/6/24	Norwalk Hospital Association – Outpatient – 1/3/25
ST Francis Hospital and Medical Center - Outpatient – 11/20/24	

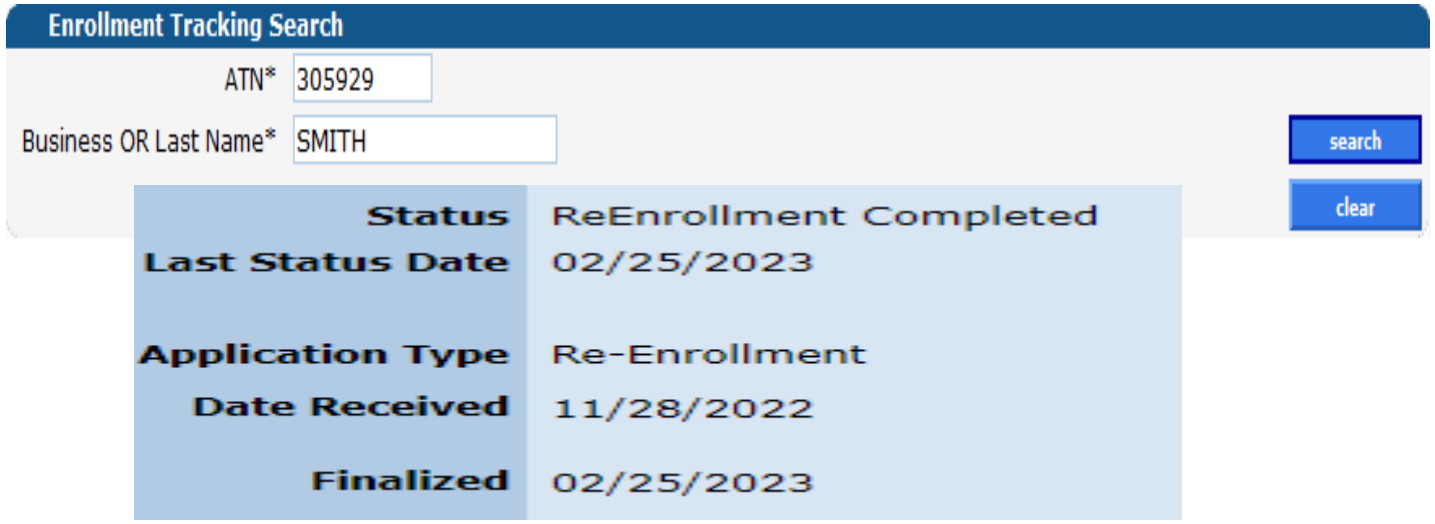
Re-enrollments

To check the status of a re-enrollment application from www.ctdssmap.com, select Provider Enrollment Tracking from either the Provider submenu or the Provider drop-down menu

Enter your ATN and Business or Last Name and click search

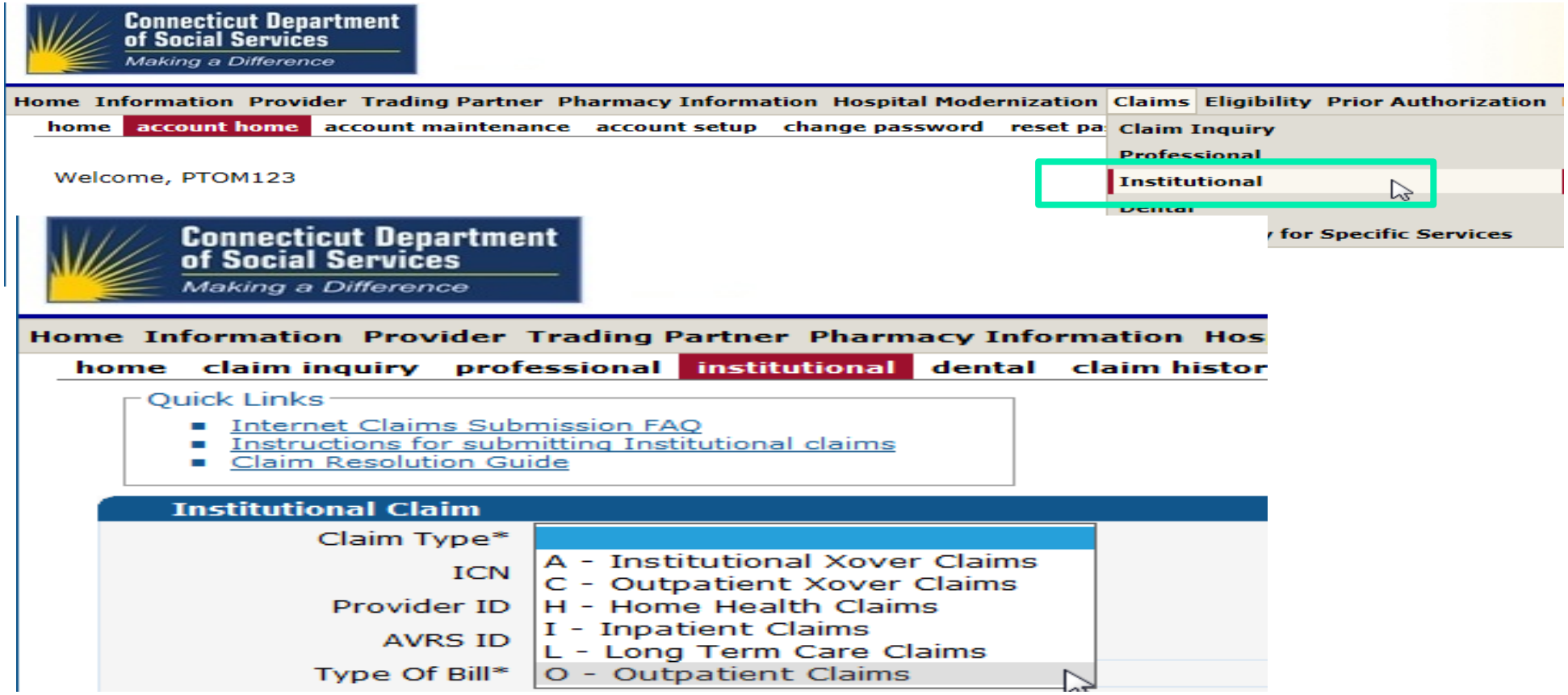
In this example DSS has reviewed and approved the application effective 02/25/2023.





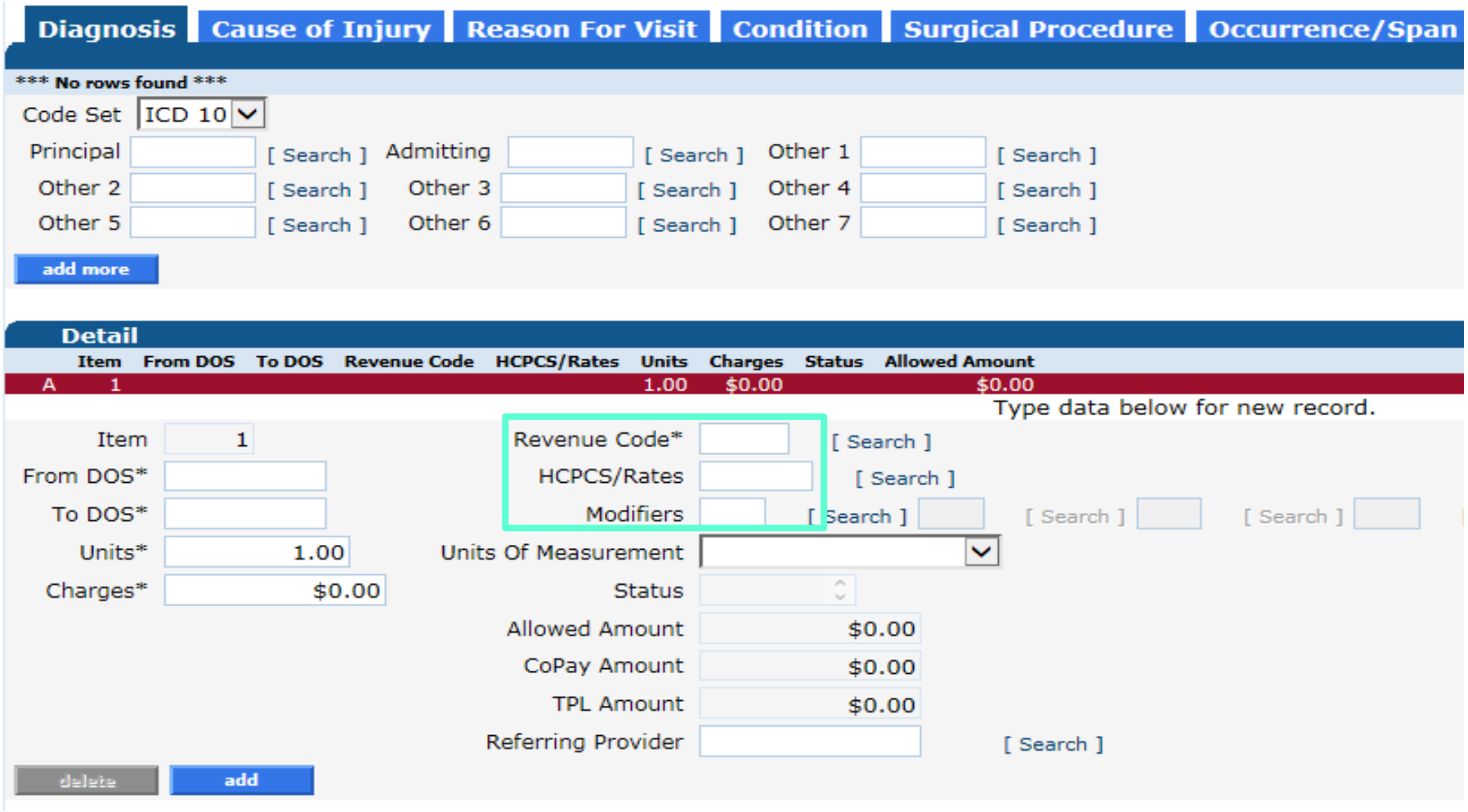
Web Claim Submission

To submit an institutional claim using the ctdssmap.com secure site, click on “Claims” on the main menu and then from the drop-down menu select “Institutional.” Once you do that you will need to select your claim type to start your claim.



Web Claim Submission

- Diagnosis and Detail Panels on an inpatient claim.



Web Claim Submission

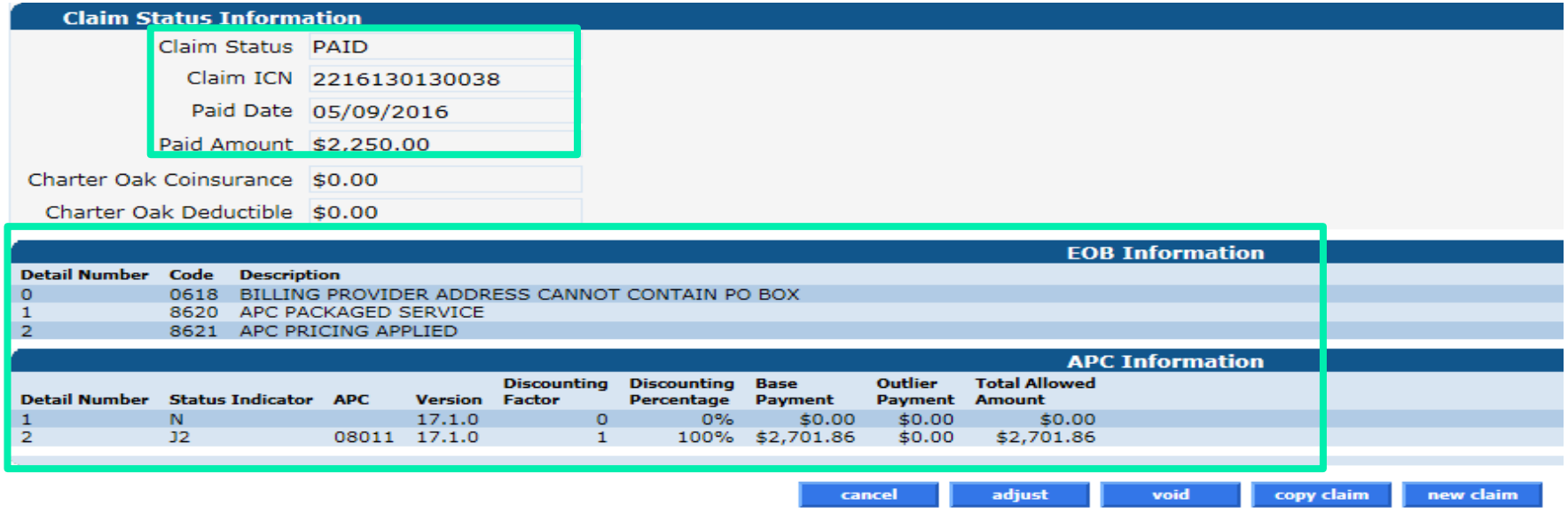
- **Revenue Code – Hospitals can use the Provider Type and Specialty to Revenue Center Code (RCC) Crosswalk on the Hospital Modernization page on the www.ctdssmap.com Web site to view the appropriate payable RCCs as limited by their scope of practice and Department policy.**
  - If the hospitals bill with an inappropriate RCC that detail will deny with EOB code 4151 “Billing Provider Not Authorized to Bill for Submitted Service for Client”.
- Please refer to the Provider Type and Specialty to Revenue Center Code Crosswalk to determine which RCCs can be used for billing.

- **HCPCS – Refer to CMAP Addendum B on the hospital modernization page for a list of HCPCS/CPT.**

- **Modifiers – A list of the modifiers that could impact your payment on your claims has been added to the Hospital Provider Manual chapter 8 “Provider Specific Claims Submission Instructions” found on the www.ctdssmap.com Web site. It is not a full list of modifiers that can be used on your claim, you should refer to the CMS Web site www.cms.gov for an entire list of modifiers.**

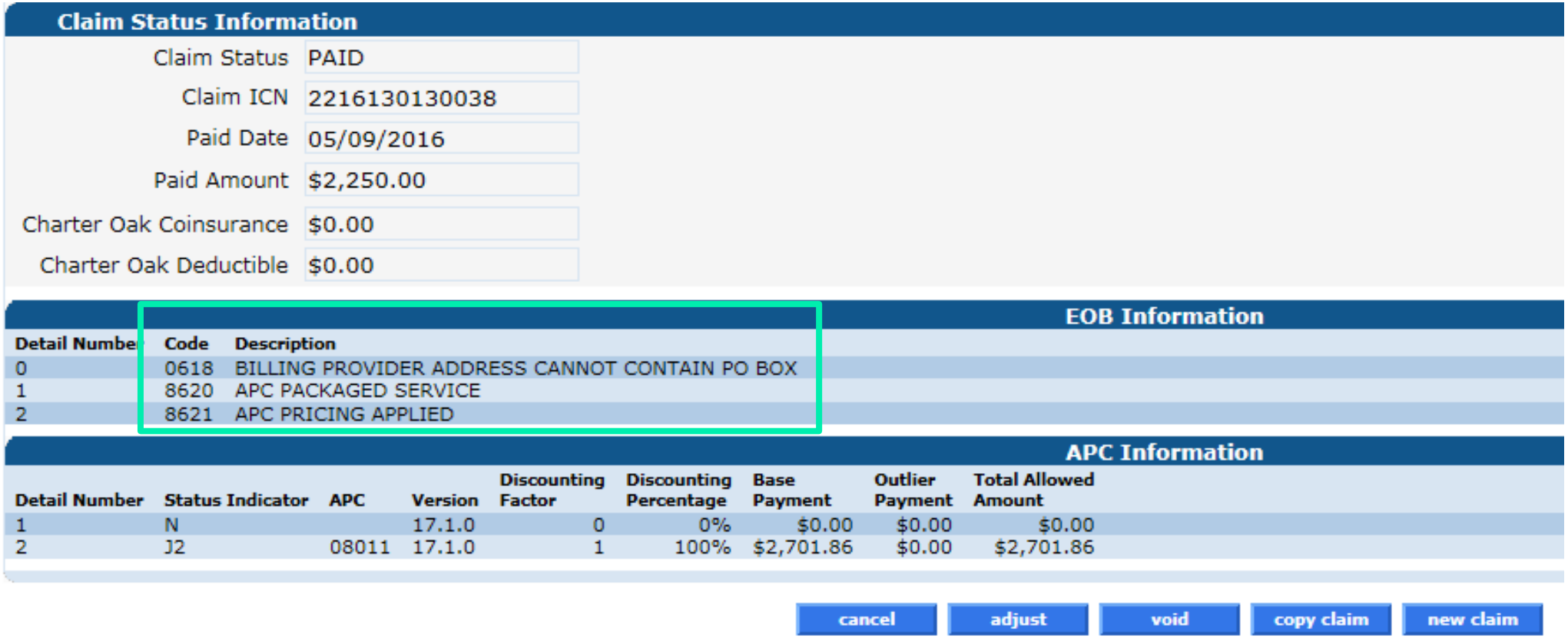
Web Claim Submission

- **Once all information is entered on your claim, hit submit to submit your claim to Gainwell Technologies. A response from Gainwell Technologies is immediate and will provide APC or DRG Information depending on your claim type.**



Web Claim Submission

- **Explanation of Benefits (EOB) information – Explains how the claim or service pays, denies or suspends.**
- **Chapter 12 of the Provider Manual may be referenced EOB codes**



Claim Status Information

Claim Status	PAID
Claim ICN	2216130130038
Paid Date	05/09/2016
Paid Amount	$2,250.00
Charter Oak Coinsurance	$0.00
Charter Oak Deductible	$0.00

EOB Information

Detail Numbe	Code	Description
0	0618	BILLING PROVIDER ADDRESS CANNOT CONTAIN PO BOX
1	8620	APC PACKAGED SERVICE
2	8621	APC PRICING APPLIED

APC Information

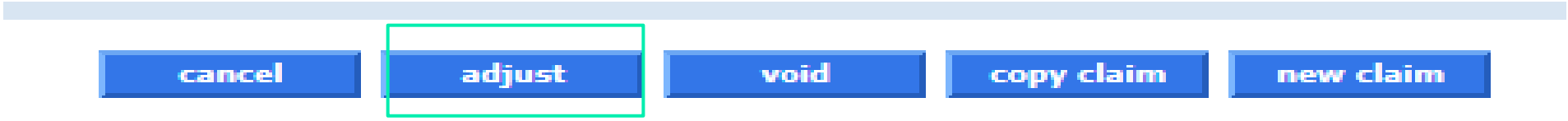
Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
1	N		17.1.0	0	0%	$0.00	$0.00	$0.00
2	J2	08011	17.1.0	1	100%	$2,701.86	$0.00	$2,701.86

cancel adjust void copy claim new claim

Web Claim Adjustments

After you submit a claim if you need to adjust a paid claim, you can perform the following steps to adjust your claim:

- Select Claim Inquiry
- Perform search to find your claim and click the search button.
- Once the claim is retrieved, make any necessary changes to the claim.
- Click the adjust button at the bottom of the claim page.

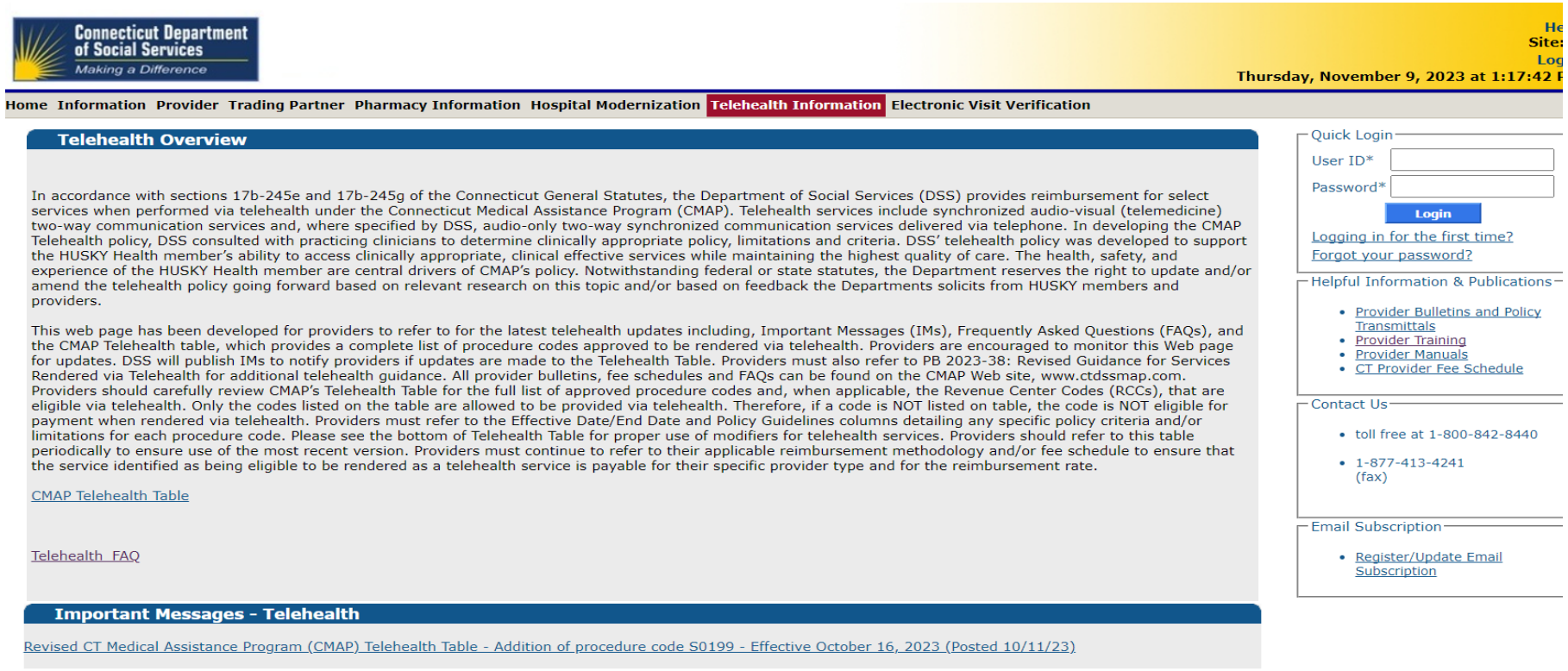


The following are web claim adjustments that can be submitted through the secure Web site www.ctdssmap.com.

- Claims that are not past timely filing.
- Claims past timely filing that will pay the same or less than the original claim without the services being modified.
- Claims that do not have an ICN# that begins with a 12 or 13.

Telemedicine Services

- PB23-38 REVISED Guidance for Service Rendered via Telehealth published May 11, 2023.
- Accessing Telehealth Policies and Covered Services Comprehensive information on telehealth can be found on the www.ctdssmap.com Web page by selecting “Telehealth Information.” This page will provide details such as the CMAP Telehealth Table, FAQs, Provider Bulletins, IMs, and all other telehealth communications. Please refer to this page periodically for updates.



Prior Authorization

Prior Authorization Requirements

- Hospitals should refer to the Connecticut Behavioral Health Partnership Web site at www.CTBHP.com > Providers > Covered Services > Authorization Schedule and select General and Psychiatric Hospital for behavioral health PA requirements.
- HUSKY Health Program benefits and authorization requirements for non-behavioral health services can be found on the HUSKY Health Web site at www.ct.gov/husky, under For Providers under Medical Management then select Benefit Grids.

Prior Authorization Reminder for Advanced Imaging Services

- Hospitals must confirm that a valid, approved authorization is on file for the appropriate Healthcare Common Procedure Coding System (HCPCS) “C” code instead of the Current Procedural Terminology (CPT) code. For a list of corresponding codes, the providers can refer to provider bulletin 2017-27 “Reminder About Use of “C” Codes for Certain Advanced Imaging Services.”
- If the authorization on file does not have a “C” code, the outpatient claim will deny, and the hospital would need to contact Community Health Network of CT (CHNCT) at 1-800-440-5071 to correct the PA.

Prior Authorization

Prior Authorizations are requested through the appropriate Administrative Service Organizations (ASOs):

- Community Health Network of Connecticut (CHNCT) at 1-800-440-5071
- Carelon Behavioral Health CT Behavioral Health Partnership (CTBHP) at 1-877-552-8247 or www.ctbhp.com

Prior authorizations are required for all nonmaternity, non-emergent admissions.

Emergency Admits: Providers must notify CHNCT (for admissions that are medical in nature) or CTBHP (for admissions that relate to behavioral health) within 2 business days. Notifications greater than 2 days from the admission date are subject to denial of services.

Maternity Admits: Effective 11/1/2022, notification of deliveries occurring at in-state and border hospitals is NOT needed.

ICU Admissions: All requests for admissions to ICU must go to CHNCT.

For admissions where the admitting diagnosis is alcohol withdrawal delirium (ICD 10 codes F10.121, F10.221, F10.231, F10.921), prior authorization requests must be submitted to the CT Behavioral Health Partnership (CTBHP) except when the member is admitted to an intensive care unit (ICU). In these instances, prior authorization requests must be submitted to CHNCT.

Decisions regarding approval or denial of elective inpatient admissions must be rendered within 5 business days.

Prior Authorization

Overlapping Inpatient Authorization

- If the hospital received 2 inpatient behavioral health prior authorization for one inpatient stay and the hospital is billing the entire stay under one inpatient claim, this could cause the incorrect amount of days to be paid on the claim.
- If the inpatient claim pays incorrectly the hospital should void the inpatient claims and contact Carelon Behavioral Health (CTBHP) to request an update to the PA to match the inpatient claim. Carelon Behavioral Health will update the PA once the units are decremented from the PA.

Inpatient Admit Change from Medical to Psychiatric

- When a HUSKY client is admitted and the primary reason for the admission is medical in nature, and then the client is subsequently transferred to a psychiatric unit, the hospital should administratively discharge (Patient Status 65) the client from medical and re-admit the client to behavioral health.
  - ➢ If the hospital does not submit with the correct patient status, the initial inpatient claim might not identify as a medical admission and deny for prior authorization due to two separate prior authorizations and two inpatient claims being billed that will overlap due to discharge date and admit date being the same.

Prior Authorization

- The outpatient hospital PA grid can be accessed via the www.ctdssmap.com Web site by selecting the “Hospital Modernization” Web page. The prior authorization grid is located under “Important Messages – Connecticut Hospital Modernization”.

RCC Code or procedure	Prior Authorization Conditions	Notes
Rehabilitation - PT, OT, SLP		
424, 434, 444	More than one evaluation per calendar year per provider.	
421, 423, 431, 433, 441, 443	Greater than two visits per calendar week per provider.	
421, 431, 441	Greater than nine visits per calendar year for certain diagnosis per provider, per service	722.xx-724.xx M43.21-M43.28, M43.36, M46.41-M46.48, M48.01-M48.08, M50.01-M53.1, M53.2x8, M53.2X9, M53.3-M54.9, M62.830, M96.1, M99.20-M99.79, 783.X, R62.0-R63.6 All mental disorders including diagnoses relating to mental retardation and specific delays in development. For a list of equivalent ICD-10 CM Diagnosis codes, please visit The DSS Fee Schedule Instructions located at www.ctdssmap.com→Provider → Provider Fee Schedule Download →Provider Fee Schedule Instructions (table 15).

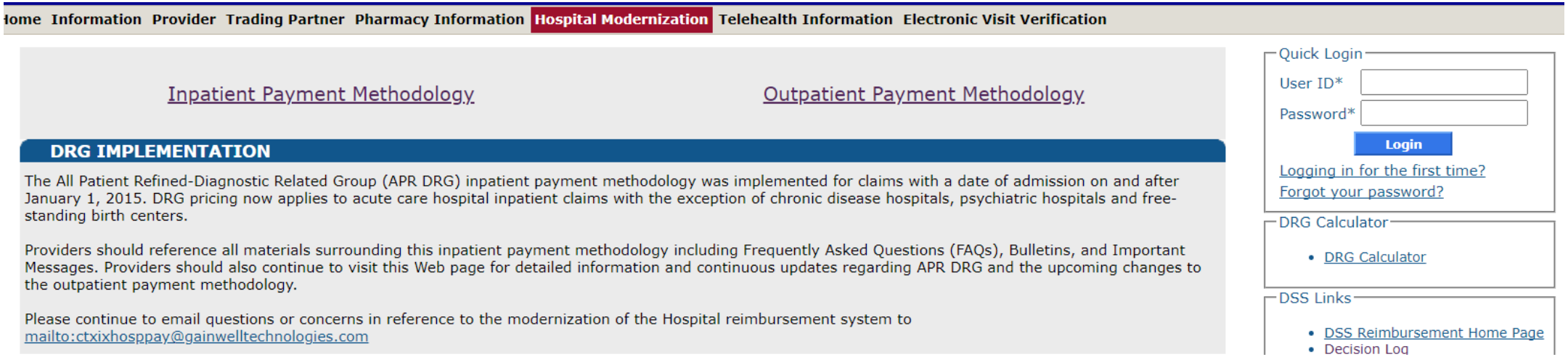
CMAP Addendum B

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 in an Excel format 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 July 1, 2024 V25.2

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
22864	Rmvl tot arthrp 1ntrspc crv	C				No		
23125	Removal of collar bone	J1	05113	35.2937	$3,084.03	APC		
58300	Insert intrauterine device	E1			$165.93	PR		
58321	Artificial insemination	T	05412	3.4980	$305.66	No		
71045	X-ray exam chest 1 view	Q3	05521	0.9908	$86.58	APC		
77061	Breast tomosynthesis uni	E1				FS	PHRAD	
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	
90471	Immunization admin	Q1	05692	0.7681	$67.12	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	
J3380	Inj vedolizumab iv 1 mg	K	01489		$22.88	APC-PR		G K
S9480	Intensive outpatient psychia					FS-CMAP	Clinic/Op - BH if RCC = 905	
U0001	2019-ncov diagnostic p	A				FS	LAB	

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 x 1) x 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 “MRI brain stem w/o dye”, payment indictor “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 indictor “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	$351.79	APC		
G0378	Hospital observation per hr	N				APC		

- The claim goes through the APC grouper and 99284 status indicator is “J2” 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

- Updates are made quarterly to the Hospital Modernization tab on the Medicaid Web site www.ctdssmap.com.

CMAP Addendum B

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

- Example: Procedure code C9158 “Inj, uzedy, 1mg”, payment type “APC-PR” and J1610 “Glucagon hydrochloride/1 mg.”

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rat	Payment Type	CT FEE SCHED	Change
C9158	Inj, uzedy, 1 mg	G	09266		$25.38	APC-PR		New
J1610	Glucagon hydrochloride/1 mg	K	09042		$187.50	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 an “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.
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 when billed without a APC payable service, 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. SURG — Surgical procedures manually priced.

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.	New - The procedure code was added by CMS. G K - The procedure code has a status indicator G or K rate change. X - A change has been made to the procedure code or status indicator. Blank - No change

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 except for 90867-90869 which pay the rate posted on the Addendum B, 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.
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.
MEDS - Prosthetic/Orthotic	MEDS - Prosthetic/Orthotic

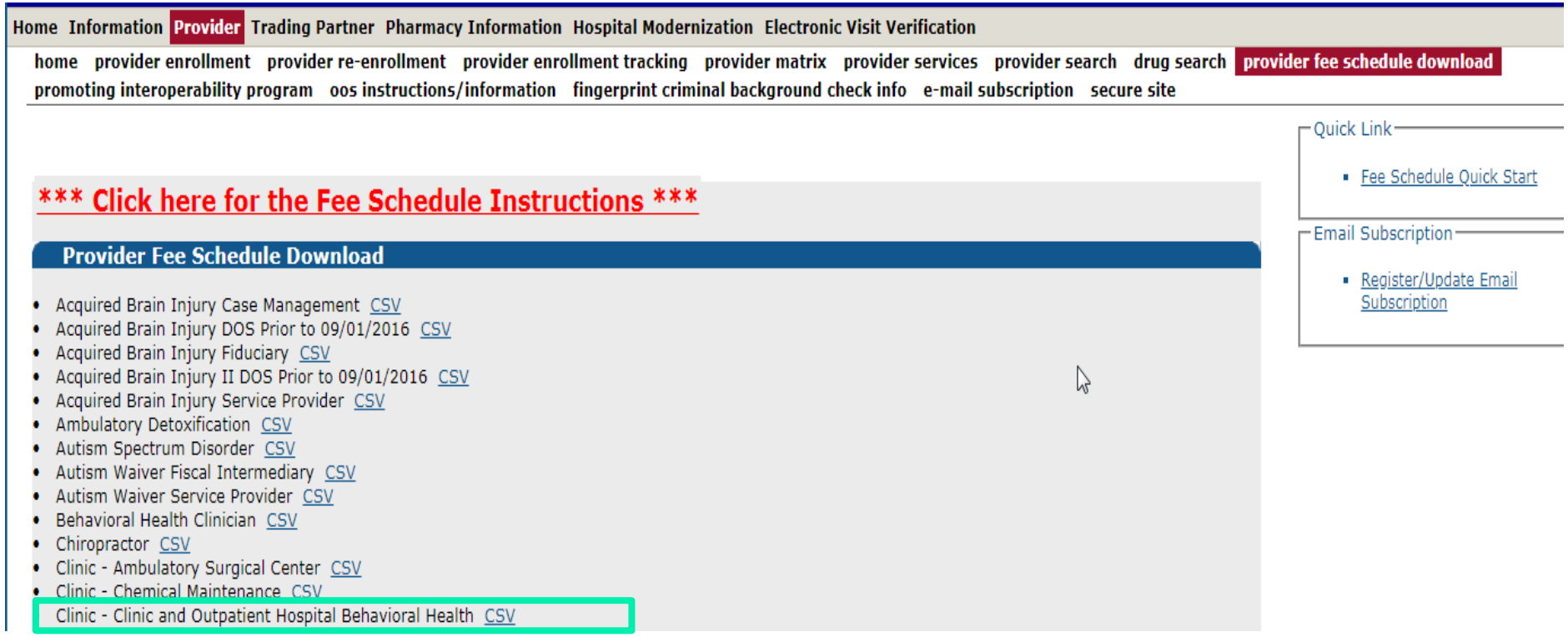
CMAP Addendum B

CMAP Addendum B - CT Fee Schedule Legend Tab Cont.

Fee Schedule Label	Fee Schedule Description
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.
MEDS - Prosthetic/Orthotic	MEDS - Prosthetic/Orthotic
NDCLOW	The National Average Drug Acquisition Cost (NADAC) established by the Centers for Medicare and Medicaid Services; when no NADAC is available for the specific drug then it is based on the lower amount between, The Affordable Care Act Federal Upper Limit (FUL); or Wholesale Acquisition Cost (WAC) plus zero (0) percent.
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. (421,423,424,431,433,434,441,443,444)

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.



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

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

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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 I	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

Rate Types

- OEC and OMH rate types are only payable for Outpatient Hospital Providers.

Provider Fee Schedule

	Hospital Outpatient Flat Fee Schedule				
RCC Code	RCC description	Rate Type	Amount	Effective I	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 spe ic rate for hospitals approved to provide services for				
	_____CARES (Child and dolescent Rapid Emergency Stabilization)				

	Rate type DEF is no overnmental 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)				

Rate Types:

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

Provider Fee Schedule

Reimbursement Rate Increases for Select Behavioral Health Services for Children

PB24-39

- The Connecticut Department of Social Services (DSS) was allocated seven million dollars towards increasing the reimbursement rates of select behavioral health services for children covered under HUSKY Health.
- As of August 13, 2024, DSS increased the reimbursement rates of select behavioral health services (including family therapy services) for HUSKY Health members ages 20 years old and under for dates of service July 1, 2024 and forward.
- Claims processed prior to August 13, 2024 where the detailed billed amount is greater than the new allowed amount will be retroactively adjusted. Gainwell Technologies will identify and reprocess these claims without any additional work on the part of providers. DSS will update this important message when the ID and reprocess will occur.
- Outpatient Hospital Behavioral Health included
- Important Message posted 8/20/2024
- Estimated publication date of the updated fee schedule is October 21, 2024

OEC	Outpt ECC rate	ECK	Outpt ECC rate kid
OMH	Outpt Mental Hlth	OMK	Outpt MentHlth kid

90785	90791	90792	90832	90833
90834	90836	90837	90838	90846
90847	90849	90853	90870	90875
90876	90880	90887	96105	96110
96112	96113	96116	96121	96125
96130	96131	96132	96133	96136
96136-TF	96137	96137-TF	96156	96158
96159	96164	96165	96167	96168
96170	96171	97153	97158	99202
99203	99204	99205	99211	99212
99213	99214	99215	99242	99243
99244	99245	99406	99407	99412
99442	99443	G8431	G8510	H0012
H0014	H0015	H0031	H0032	H0032-TS
H0035	H0046	H2012	H2013	H2014
H2019	S9480	S9484	S9484-HM	S9484-HT
S9485	S9485-HT	T1016	T1017	

Outlier Payments

In addition to services being paid via the APC methodology outpatient claim might be eligible for an outlier payment.

Outlier adjustments ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers.

- **Similar to Medicare, in order for an outpatient claim to qualify for an outlier payment, two thresholds must <u>both</u> be met:**
  - Multiple Threshold – The multiple threshold is met when the cost of furnishing an APC service or procedure exceeds the APC payment amount based on a defined multiplier.
  - Fixed-Dollar – The fixed-dollar threshold is met when the cost of furnishing an APC service or procedure exceeds the APC payment amount plus a fixed amount.

All Patient Refined-Diagnostic Related Group (APR DRG)

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 ctxixhosppay@gainwelltechnologies.com.

APR DRG

3M Science. Applied to Life.™

ACCESS AGREEMENT

PLEASE READ THE FOLLOWING TERMS AND CONDITIONS CAREFULLY BEFORE CONTINUING.

THE PURPOSE OF THIS ACCESS AGREEMENT ("Agreement") IS TO GIVE INTERESTED PARTIES THE OPPORTUNITY TO REVIEW AND EVALUATE 3M™ APR DRGs (3M™ All-Patient Refined Diagnosis Related Groups), 3M™ CRGs (3M™ Clinical Risk Groups), 3M™ PFEs (3M™ Patient Focused Episodes), 3M™ PFPs (3M™ Population Focused Preventables), 3M™ PPCs (3M™ Potentially Preventable Complications), and/or 3M™ PPRs (3M™ Potentially Preventable Readmissions).

AS USED IN THIS AGREEMENT, THE WORD "YOU" MEANS: (i) YOU, IN YOUR INDIVIDUAL CAPACITY, IF YOU ARE USING THE MATERIALS (AS DEFINED BELOW) FOR PURPOSES OF REVIEW AND EVALUATION, AND/OR (ii) YOUR EMPLOYER, IF YOU OR OTHERS WITHIN YOUR ORGANIZATION WILL USE THE MATERIALS ON YOUR EMPLOYER'S BEHALF FOR THE PURPOSES OF REVIEW AND EVALUATION. THE MATERIALS ARE AVAILABLE FOR YOUR ACCESS AND USE ONLY ON THE CONDITION THAT YOU AGREE TO THESE TERMS AND CONDITIONS. IF YOU DO NOT AGREE TO THESE TERMS AND CONDITIONS, PLEASE DISCONTINUE. BY CLICKING "ACCEPT", OR BY OTHERWISE USING OR ACCESSING THE MATERIALS, YOU SIGNIFY YOUR AGREEMENT TO BE BOUND BY THESE TERMS AND CONDITIONS.

1. **Materials.** As used herein, the term "Materials" shall mean the 3M™ APR DRG software and the Definitions Manuals for the 3M™ APR DRG, 3M™ CRG, 3M™ PFE, 3M™ PFP, 3M™ PPC, and 3M™ PPR classification systems, including their respective content (the logic, formulas, algorithms, and software code for selecting a particular code for defining or assigning a particular patient classification or subset of patient classifications or selecting a particular code or subset of codes contained or reflected in such Materials). Title to the Materials, and the ownership of all copyright, trademark, patent, trade secret, or any other right of a similar kind or nature arising under the laws of any country in the world (collectively, "Intellectual Property Rights") thereto, are the property of 3M and/or its suppliers.
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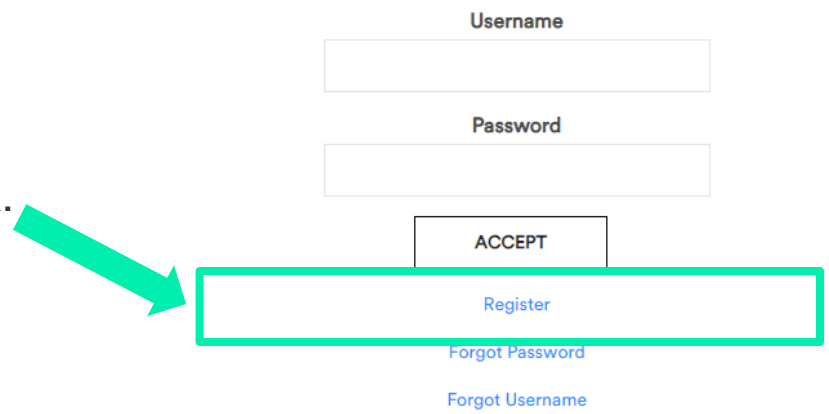
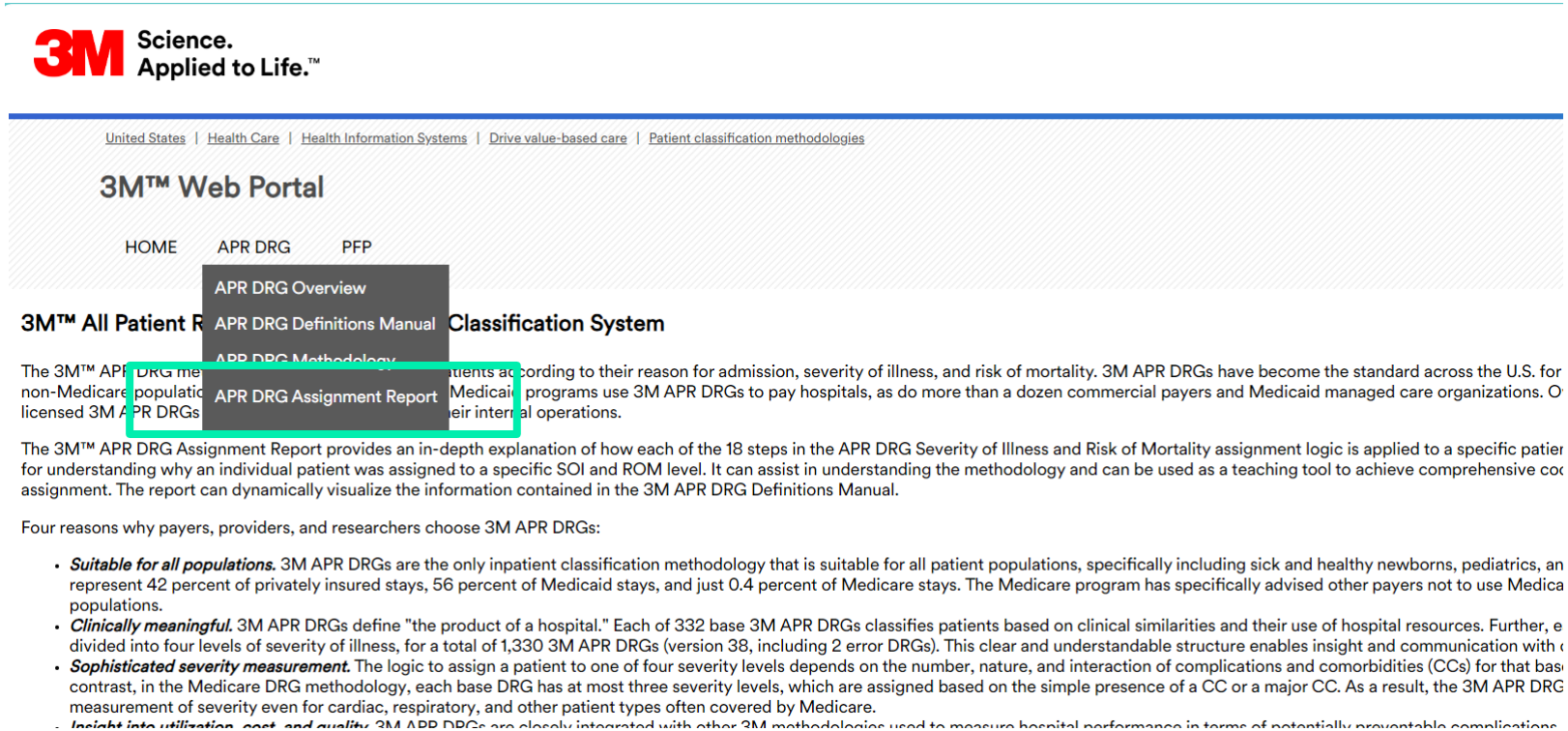


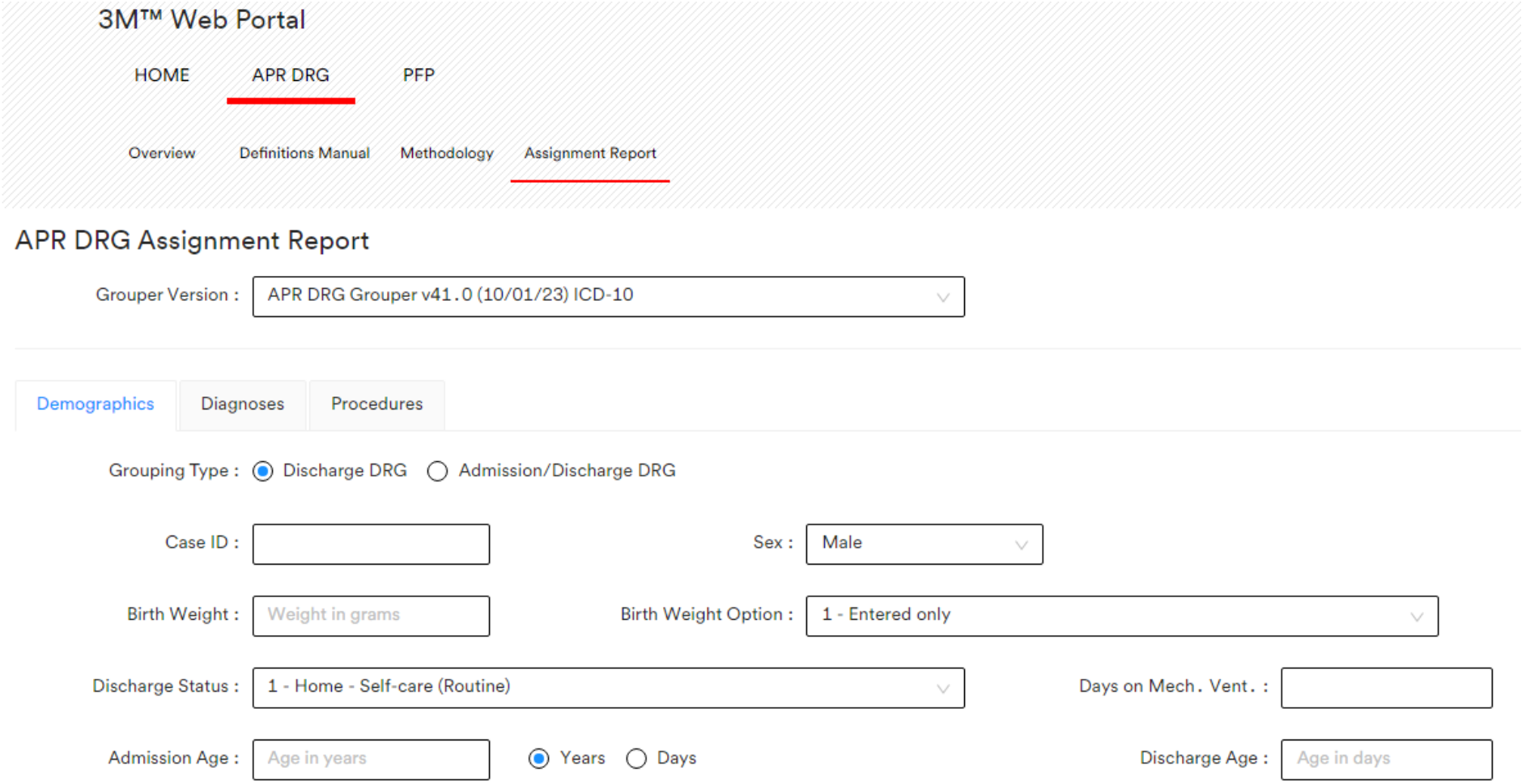
APR DRG

- Home Page
- Click on APR DRG
- Then click on Assignment Report In Drop down under APR DRG



APR DRG

- Demographics Tab



APR DRG

- Demographics Tab

Grouper Version –

- Select from drop down “APR DRG Grouper” v41.0 (10/01/23) ICD-10 please note: “APR DRG Grouper” v42.0 (10/01/24) ICD-10 (coming soon).

Grouping Type –

- Select: Admission/Discharge DRG (Excludes non-POA Complication of Care codes).

Admission Date and Discharge Date – Enter the date of admission and discharge date of the inpatient stay

Sex – Select Male, Female, or Unknown.

Discharge Status – Select the patient status on the claim from the drop-down selection.

Admission Age – Enter the age of the client at the time of admission in days or years.

APR DRG

Demographics Tab

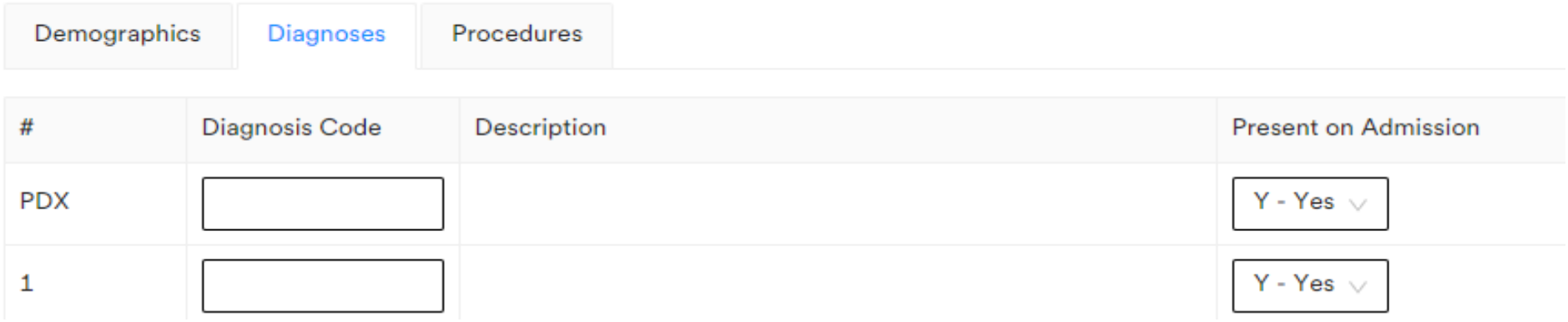
Birth Weight (Grams)* – Enter weight of newborn in grams.

Birth Weight Option* – Select 7 “Entered or coded w/default, X-chk”.

*Birth Weight Option and Birth Weight (Grams) only needs to be filled in if you are trying to determine the DRG code on a newborn claims.

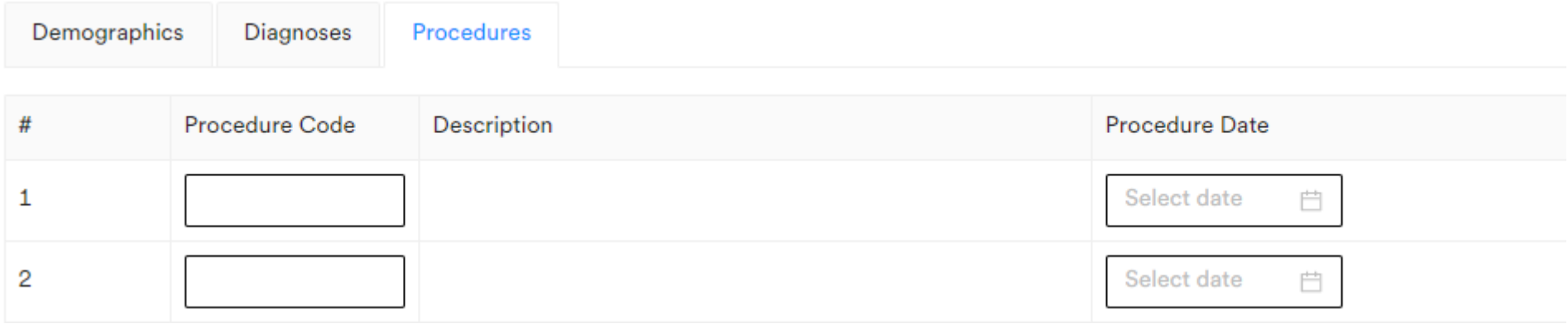
APR DRG

- “Diagnoses” Tab
- 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

- Procedures Tab
- Enter the ICD-10 Surgical Code and Procedure Date.



APR DRG

- Once all information is entered hit the Generate Report Button to get the report on your request which will include the APR DRG and Severity of Illness (SOI) code for the inpatient stay. In this example the inpatient claim will process based on DRG code 2542.

3M™ APR DRG Assignment Report

APR DRG Version 38.0
Codes FY 2021 ICD-10

Patient ID :	null	**Sex :**	Male
Age in Years :	25	**Status :**	1 - Home - Self-care (Routine)
Days Mech Vent (DMV) :		**DMV Source :**	6 - No DMV

Grouper Results for Admission APR DRG

MDC:	6 - DIGESTIVE SYSTEM
All Patient Refined DRG :	254 - OTH DIGESTIVE SYSTEM DX
Severity of Illness :	2 - Moderate Patient Severity of Illness
Risk of Mortality :	1 - Minor Patient Risk of Mortality
Medical/Surgical DRG :	Medical
Return Code :	0 - DRG assigned

APR DRG

- DRG Calculator

Once the 3M tool sets a DRG code 2542, 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 ctxixhosppay@gainwelltechnologies.com with a screen shot of the results from the 3M tool or DRG calculator.

APR DRG

- DRG Calculator

Connecticut Medical Assistance Program APR DRG Pricing Calculator

Effective for Discharges 1/1/2024 and Forward

Indicates data to be input by the user

Information	Data	Comments or Formula
INFORMATION FROM THE CLAIM		
Submitted charges	$37,500.00	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	6	Used for transfer pricing and non-covered days adjustments.
Client eligible days	6	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 outliner 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	7221	From 3M-PC software version 41.
APR DRG description	FEVER AND INFLAMMATORY CONDITIONS	Look up from DRG table.
APR DRG weight	0.3814	Look up from DRG table.
Average length of stay for this APR DRG	1.95	Look up from DRG table.
HOSPITAL INFORMATION		

APR DRG

DRG Calculator

- Each field is defined under the Calculator Instructions
- Green fields 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 October 24, 2023 and discharged on October 30, 2023 the hospital would enter 6.

APR 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 October 24, 2023, and transferred on October 30, 2023, the hospital would enter 7.

- 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.

APR 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).

APR DRG

DRG Calculator

Example – Inpatient stay admitted on October 24, 2023, and discharged on October 30, 2023, with a discharge status 01 for a female client 34 years old. Total charges $37,500, APR DRG 2542, APR DRG weight 0.6275, Average Length of Stay (ALOS) of 2.78, and DRG Outlier Threshold of $30,595.85. The Hospital base rate is $12,361.61 and Hospital cost-to-charge ratio is 0.28166.

- 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.

APR DRG

- DRG Calculator – Payment Amount

29	**APR DRG BASE PAYMENT**		
30	Pre-transfer APR DRG base payment	$5,674.12	E24*E21
31	**TRANSFER PAYMENT ADJUSTMENT**		
32	Is a transfer adjustment potentially applicable?	No	E11
33	Transfer base payment	N/A	IF(E32="Yes",(E30/E22)*(E9+1), else "N/A")
34	Is transfer base payment < pre-transfer base payment?	N/A	IF(E32="Yes",IF(E33<E30,"Yes", else "No"), else "N/A")
35	Full Stay APR DRG base payment	$5,674.12	IF(E34="Yes",E33, else E30)
36	**OUTLIER ADD-ON DETERMINATION**		
37	Hospital specific estimated cost of the stay	$11,919.38	(E7-E8-E12-E13-E14) * E24
38	Does this claim require an outlier payment?	No	IF E27 > E37 "No", Else "Yes"
39	Cost outlier payment	$0.00	IF E38 = "Yes" (E37 - E27) * E28, Else 0
40	**NON-COVERED PAYMENT ADJUSTMENT**		
41	Are covered days less than length of stay	No	IF E10 < E9 "Yes", Else "No"
42	Non-covered day reduction factor	1.000000	IF E41 = "Yes", (E10/E9)) Else 1.0
43	Non-covered adjusted APR DRG base payment	$5,674.12	IF E41 = "Yes", IF(E32="Yes",(E30/E22)*(E10+1),((E10/E9)*E30)) else E35
44	Non-covered adjusted outlier payment	$0.00	E39 * E42
45	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**		
46	APR DRG allowed amount	$5,674.12	IF(E43>E30,E30+E44,E43+E44)
47	Does the charge cap apply?	No	IF E46 > E7 "Yes", Else "No"
48	Third Party Liability	$0.00	E15
49	Payment amount	**$5,674.12**	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 $5,674.12. (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.

Discharge Delay Days/Value Based Payments

Discharge Delay Days/Value Based Payments (VBP)

PB23-63 **Pediatric Inpatient Psychiatric Services: Interim Voluntary Value-Based Payment Opportunity for Increasing Needed Capacity and Interim Rate Add-On for Acuity and Revised Discharge Delay Policy** – Published 10/20/2023

1. Interim Voluntary VBP for Increasing Needed Capacity

Effective for dates of service from December 1, 2021, through December 31, 2024, the following categories of Connecticut hospitals may be eligible for a VBP that includes a rate add-on to the per diem rate based on their ability to: 1) Increase actual bed capacity and utilization for pediatric inpatient psychiatric services (individuals under the age of 18), and 2) Comply with the requirements detailed below that are designed to improve the quality of care over the long term.

2. Interim Rate Add-On for Acuity

Effective for dates of service from December 1, 2021 through December 31, 2024, the following hospitals that provide pediatric inpatient psychiatric services for individuals under the age of 18 and bill using the per diem rate for such services and psychiatric hospitals may be eligible for an interim acuity-based rate add-on to the applicable per diem rate if authorized by the behavioral health ASO in accordance with the standards set forth.

3. Revised Discharge Delay Policy

Effective for dates of service from December 1, 2021 until December 31, 2024 unless otherwise notified, the Medically Necessary Discharge Delay policy for pediatric inpatient psychiatric services is revised as detailed in the bulletin and this revised policy supersedes any provisions in provider bulletin 2012-32 to the extent that any of those provisions are inconsistent with this revised policy. This policy remains applicable only to CMAP members under age 19.

4. Proposed Future Value-Based Payment Model

Effective for dates of service on and after January 1, 2025, all short-term general hospitals, short-term children's general hospitals, private psychiatric hospitals, and chronic disease hospitals in Connecticut and applicable qualifying border hospitals that provide pediatric inpatient psychiatric services may voluntarily choose to participate in an updated value-based payment (VBP) program, which is currently under development and will include various performance measures and other metrics to be determined.

Discharge Delay Days/Value Based Payments

Hospital Eligibility:

- licensed short-term general hospital with a pediatric inpatient psychiatric unit
- licensed short-term children's general hospital with a pediatric inpatient psychiatric unit
- private psychiatric hospital
- chronic disease hospital with a pediatric inpatient psychiatric unit or a dedicated unit for providing specialized behavioral health services to children, including autism spectrum disorder services

This rate add-on is also potentially available to border hospitals in accordance with the same conditions as in-state hospitals and that also meet all of the following parameters:

- licensed short-term general hospital with a pediatric inpatient psychiatric unit or a private psychiatric hospital
- located no more than 10 miles from the Connecticut border and
- has no fewer than 50 episodes of pediatric inpatient psychiatric services paid by Connecticut Medicaid each calendar year beginning in 2019 and continuing on an ongoing basis.

Discharge Delay Days/Value Based Payments

Requirements for Interim Voluntary VBP for Increasing Needed Capacity:

This rate add-on is available only if, on an ongoing basis, the hospital successfully maintains and demonstrates full compliance with all of the following requirements, as determined by DSS or its behavioral health administrative services organization (ASO):

- Request Process
- Certification of Beds
- Minimum Increase in Beds
- Licensing and Certificate of Need (CON) Compliance
- Bed Tracking
- Post-Discharge Follow-Up
- Comprehensive Services
- Quality and Care Transitions’
- Suicide Prevention
- Additional Data Reporting

Discharge Delay Days/Value Based Payments

Interim Voluntary VBP for Increasing Needed Capacity

Billing Instructions for Rate Add-on Amount for Acute Care and Children's Hospitals:

- If approved by DSS for Acute Care and Children's Hospitals and authorized by Carelon for rate add-on amount in accordance with the standards set forth above, the hospital will need to bill those authorized days with RCC code 160 to receive rate add-on amount. Private Psychiatric Hospitals should continue to use their current approved RCC codes when billing.

Discharge Delay Days/Value Based Payments

Interim Rate Add-On for Acuity

If authorized by the behavioral health ASO, the hospital will add Revenue Center Code (RCC) 169 to the claim of the child and the acuity-based rate add-on will increase the per diem rate by 10% for the specific patient bed days for which the add-on was authorized, which is calculated on the hospital's per diem rate for the date of service, which, if applicable to the hospital, would include the rate add-on for increasing needed capacity set forth above. The acuity-based rate add-on is not applicable to the medically necessary discharge delay bed days (regardless of whether or not such bed days fall into the revised discharge delay policy set forth below). This is not a diagnosis-based rate add-on; however, the following conditions and/or behaviors are provided as examples of conditions that may warrant a rate add-on if the child's condition meets the standard for acuity detailed above:

- Severe problem sexual behavior, such that the child may endanger the welfare of another child on the unit;
- Severe aggression, such that the child may pose a risk to self, the staff or the other children;
- Severe risk of self-harm, including recent history of lethal suicide attempts;
- Eating disorder, such that advanced medical and behavioral health services are required; or
- Physical and/or intellectual disability and/or autism spectrum disorder such that the disability inhibits or negatively impacts participation in therapeutic services.

Discharge Delay Days/Value Based Payments

Interim Rate Add-On for Acuity

Billing Instructions for Acuity-Based Rate Add-On for all hospitals:

If authorized by Carelon for an acuity-based rate add-on in accordance with the standards set forth above, the prior authorization will be authorized for the approved days with revenue code/list 2069. The hospital will need to bill those authorized days with RCC code 169 to receive the acuity-based rate add-on.

If the hospital received two (2) authorizations for an inpatient stay, one for acute behavioral health (BH) days not subject to the rate add-on and one authorizing the acuity-based rate addon, the hospital will need to bill their inpatient claims with one detail with the acute BH room & board RCC for the days authorized only for acute BH days and a second detail with RCC 169 for the days also authorized at the acuity-based add-on rate.

Failure to bill RCC 169 correctly could cause claims to process at an incorrect rate or deny.

Discharge Delay Days/Value Based Payments

Revised Discharge Delay Policy

Due to the current demand for acute pediatric inpatient psychiatric services in conjunction with a decreased capacity for community-based behavioral health services, the hospital will be paid the full applicable per diem rate (not the discharge delay rate) when all of the following have been confirmed by the behavioral health ASO on a case-by-case basis as part of the authorization process for each applicable prior authorization or concurrent review request:

- the hospital has made and continues to make every attempt to secure the appropriate discharge plan that best meets the individual's needs;
- the ASO confirms that the discharge plan is appropriate, but that plan cannot be implemented for the applicable dates of service due to lack of availability of community-based services that are appropriate for the individual's discharge plan; and
- that active treatment is occurring in the hospital that is based on the individual's needs and meets medical necessity. This authorization process will enable the hospital to bill for all bed days meeting the above requirements using the same revenue center code used to bill the standard psychiatric per diem rate.

Reference for Pediatric Discharge Delays and the use of RCC 224: PB12-32 Hospital Inpatient Services

Discharge Delay Days/Value Based Payments

Proposed Future Value-Based Payment Model

Hospitals that provide pediatric inpatient psychiatric services that were not able to increase bed capacity under the above-referenced initial phase may still be eligible to seek to participate in the VBP program, in accordance with all applicable requirements, which are also under development.

Hospitals that do not elect to participate in the VBP are not eligible for the VBP rate methodology.

The Department will implement value-based payment with data collection to start later in the year pending implementation in 2025.

Regulations / Policies

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** • 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

Select a provider type

Hospital
Hospital Inpatient: NEW Requirements Eff. 1-1-15
Hospital Outpatient: NEW Requirements Eff.7-1-16
Independent Clinical Lab
Independent Radiology

Regulations / Policies

Provider Manuals

Chapter 1 – Introduction

- Provides information on the CT Medical Assistance Program, the Department of Social Services' and Gainwell Technologies responsibilities and resources

Chapter 2 – Provider Participation Regulations

- Details the CMAP regulations for provider participation

Chapter 3 – Provider Enrollment

- Provides information on provider eligibility in regard to provider enrollment and re-enrollment

Chapter 4 – Client Eligibility

- Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability

Chapter 5 – Claim Submission Information

- Provides information on general claims processing, billing requirements and timely filing guidelines

Chapter 6 – EDI Options

- Provides information on electronic claim submission and electronic RAs

Regulations / Policies

Provider Manuals

Chapter 7 – Regulations/Program Policy

- This section contains the Medical Services Policy sections that pertain to the chosen provider type

Chapter 8 – Billing Instructions

- Provides information on provider specific billing requirements and instructions

Chapter 9 – Prior Authorization

- Provides information on how to obtain Prior Authorization for designated services

Chapter 10 – Web Portal/Automated Voice Response System (AVRS)

- Provides information on both the AVRS and the Web Portal functions

Chapter 11 – Other Insurance/Medicare Billing Guides

- Provides claim-type specific information on other insurance and Medicare billing

Chapter 12 – Claim Resolution Guide

- Provides descriptions of common EOBs and, if applicable, information to resolve the errors

Frequent Claim Denials

Chapter 12 Claim Resolution Guide

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** • Carrier Listing Sorted by Name • Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
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8	Provider Specific Claims Submission Instructions Select a provider type View Chapter 8
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Chapter 12 Claim Resolution Guide

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Frequent Claim Denial

EOB code 0305 “APC - Medical visit on same day as type T or S procedure w/o modifier 25 - significant separate E&M service"

Cause

- A clinic or emergency department visit (status indicator V-clinic or emergency department visit paid under OPPS) has been billed without modifier 25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the same date of service as a significant procedure (status indicator S or T Significant Procedure payable under OPPS).

Resolution

- Correct the claim by adding modifier 25. Re-submit the claim. If there is already a modifier 27 on that detail, add the modifier 25 in the 2nd position.

Frequent Claim Denial

EOB Code 0690 Principal diagnosis invalid as discharge

Cause

- The Inpatient claim contains an invalid principal diagnosis code. The International Classification of Diseases, Clinical Modification identifies diagnosis codes that require a more specific diagnosis code be submitted on the claim.
  An ICD-10 example of this is E11 (Diabetes Mellitus).

Resolution

- Change the principal diagnosis code on the claim to a more specific ICD-10 diagnosis code and resubmit the claim.

Cause

When an incorrect primary delivery diagnosis code is used.

Resolution

Review the Important Message link below for list of approved codes for inpatient delivery stays and prior authorizations. Posted in 2021

Inpatient Delivery Stays and Prior Authorization (PA) Reminder

Frequent Claim Denial

EOB code 0316 “APC - Only incidental services reported"

Cause

- The outpatient claim was submitted with only incidental services being billed.

Resolution

- Please verify the procedures submitted on the claim. If an outpatient claim was submitted without an APC payable service and just packaged services will be denied.

Frequent Claim Denial

EOB code 0337 “APC Total amount allowed on APC claim is zero.”

Cause

- An 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

- 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.

Resources

Resources

Claims, Enrollment, and Eligibility Questions should be directed to:

- Gainwell Technologies Provider Assistance Center (PAC) 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays

  If hospitals are experiencing extended call wait times, hospitals may email the provider assistance call center with their question at ctdssmap-provideremail@gainwelltechnologies.com. Please be sure to include your name and phone number with your inquiry

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

- Gainwell Technologies Electronic Data Interchange (EDI) Help Desk 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

Prior Authorizations:

- Community Health Network of Connecticut (CHNCT) at 1-800-440-5071
- Carelon Behavioral Health CT Behavioral Health Partnership (CTBHP) at 1-877-552-8247 or www.ctbhp.com

Third Party Insurance issues:

HMS 1-866-252-0671 or CTinsurance@gainwelltechnologies.com

Wrap Up and Questions

Thank you so much for attending today's workshop!

Please fill out survey provided in MSTeam's chat.