

interChange Provider Important Message

Hospital Monthly Important Message Updated as of 06/19/2019

***all red text is new for 06/19/2019**

CMAP Addendum B April 2019

The Department of Social Services (DSS) will be updating the CMAP Addendum B to incorporate the 2019 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) for dates of service April 1, 2019 and forward to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Payment rate changes for procedure codes assigned a status indicator G or K were updated and loaded into the system with an April 1, 2019 effective date on March 26, 2019. DXC Technology has determined there were no outpatient claims with date of services April 1, 2019 that processed with the incorrect payment rate.

Any NEW procedure codes that were added to CMAP Addendum B with an effective date of April 1, 2019 and forward were updated in the system on April 30, 2019.

The following procedure code has an effective date of February 1, 2019; Q2041 "Axicabtagene ciloleucel car+"

The April changes have been posted to the CMAP Addendum B Changes document on the Hospital Modernization page under "CMAP Addendum B Changes and Historical Versions".

The changes can be identified by the following indicators:

- "G or K" - A change has been made to the payment rate (status indicator G or K).
- "New" - The procedure code was added by CMS
- "X" - A change has been made to the procedure code or status indicator.

Older versions of CMAP Addendum B can be found under the Hospital Modernization page under "CMAP Addendum B Changes and Historical Versions".

Supplemental Payment

For inpatient discharges that occurred between October 1, 2018 and April 14, 2019, a supplemental payment will be paid out to the hospitals. This payment is scheduled to occur by the end of June 2019. This payout will make up for the difference between what was paid without the adjustment factor and what would have been paid if the adjustment factor was in effect for that period.

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

- 06/11/2019 - Any inpatient claims with a discharge date of October 1, 2018 to November 13, 2018 that processed at the incorrect DRG weight, ALOS or outlier amount was identified and reprocessed in a special claim cycle Friday June 14, 2019 and appeared on your June 18, 2019 RA. The monies due from the special claim cycle will be recouped on your June 25, 2019 Remittance Advice (RA) and will be paid back out in the supplemental payment which will be paid out directly to the hospital.

interChange Provider Important Message

Newborn DRG codes 5891 - 5894

- 6/11/2019 - DSS updated the DRG weights, ALOS and Outlier Threshold for DRG codes 5891 - 5894 on February 14, 2019 effective for date of discharges October 1, 2015 to September 30, 2018. Any inpatient claims with a discharge date of October 1, 2015 and forward that processed between May 11, 2018 and February 14, 2019 at the incorrect DRG weight, ALOS or outlier amount. The impacted claims have been identified and reprocessed and appeared on your May 29, 2019 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 50.

Provider Bulletins

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

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

Provider Bulletin 2019-33 - Updating the Tuberculosis Limited Benefit

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

Provider Bulletin 2019-31 - Implementation of Electronic Delivery of Letters Update - Final Phase

The Department of Social Services (DSS) is pleased to provide an update on the final phase of the electronic delivery of letters implementation. As previously communicated in provider bulletin PB19-15, Implementation of Electronic Delivery of Letters, this initiative replaces the mailing of many paper letters that providers currently receive from the Connecticut Medical Assistance Program (CMAP) through the United States Postal Service (USPS).

Trauma questionnaire letters for June 2019 were sent to the hospitals through eDelivery.

Provider Bulletin 2019-25 - Removal of Prior Authorization/Registration for Behavioral Health Professional Services Rendered During a Medical Inpatient Stay

Effective for inpatient admissions on or after May 1, 2019, Prior Authorization (PA)/registration will no longer be required for behavioral health professional services rendered by a Physician, Advanced Practice Registered Nurses (APRNs) and Physician Assistant during a medical inpatient stay in Place of Service (POS)/Facility Type Code (FTC) 21 - Inpatient Hospital.

Provider Bulletin 2019-22 - Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)

The Department of Social Services (DSS) and DXC Technology has published the Connecticut Medical Assistance Program Electronic Claims Submission, Remittance Advice (RA), Check and Electronic Funds Transfer (EFT) issue dates and 835 schedule for July 2019 to December 2019.

interChange Provider Important Message

Hospital Refresher Workshop Material

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

Inpatient Behavioral Health Prior Authorization Request

When the hospital request prior authorizations for an inpatient behavioral health stays from Beacon Health Options, they should no longer be requesting an additional unit for the discharge day. The hospital should only be requesting the actual number of days the client was in the hospital, not including the date of discharge.

Medicare Covered Services Only - Qualified Medicare Beneficiary (QMB)

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

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

TPL Audit Report - June 2019

The Third Party Audit reports were sent to the following hospitals on June 6, 2019:

Hartford Hospital, St. Francis Hospital, St. Mary's Hospital, The Hospital of Central Connecticut, Milford Hospital, Yale New Haven Hospital, Danbury Hospital, Greenwich Hospital.