



Connecticut Medical Assistance Program
Policy Transmittal 2014-34

Roderick L. Bremby, Commissioner

Provider Bulletin 2014-91
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Effective Date: January 1, 2015

Contact: Nina Holmes @ (860) 424-5486

TO: Physicians, Physician Assistants, Advanced Practice Registered Nurses, Nurse-Midwives, Podiatrists, Optometrists and Oral Surgeons

RE: 1) 2015 Physician Fee Schedules HIPAA Compliant Update

- 2) Behavioral Health Screens
- 3) Prior Authorization Changes for Select Services
- 4) Reimbursement for Select Manually Priced (MP) Services
- 5) Modifier 59
- 6) Reimbursement for Practitioner Services Rendered in a Facility Setting

HIPAA Compliant Update

The purpose of this policy transmittal is to inform providers that, effective for dates of service **January 1, 2015 and forward**, the Department of Social Services is incorporating the 2015 HIPAA compliant update changes within the Physician Office and Outpatient, Physician Surgical, Physician Anesthesia and Physician Radiology Fee Schedules. The Department is making these changes to ensure that the physician fee schedules remain compliant with the Health Insurance Portability and Accountability Act.

Behavioral Health Screens

Effective for dates of service January 1, 2015 and forward there will be a new CPT code for billing behavioral health screens (BH screens).

- 96127 (brief emotional or behavioral assessment)

Providers should use CPT code 96127 when billing for BH screens instead of CPT code 96110. Providers should continue to use CPT code 96110 when billing for developmental screens and should note that the description has been revised in order to distinguish it from CPT code 96127.

- 96110 (developmental screening (e.g., developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument)

As communicated in PB 2014-43, the Department requires physicians (excluding psychiatrists), APRNs (excluding psychiatric APRNs), and physician assistants to use modifiers U3 (positive developmental / BH screen) and U4 (negative developmental / BH screen) when billing for developmental and behavioral health screens for HUSKY Health clients under the age

of eighteen. This policy will continue to be required for developmental screens billed as CPT code 96110, and effective for dates of service January 1, 2015 and forward, will be required for BH screens billed as CPT code 96127. Please refer to PB 2014-43 and PB 2014-58 for more information regarding developmental and behavioral health screens, including how to locate validated tools.

Prior Authorization (PA) Requirements for Select Services

Effective for dates of service **February 1, 2015 and forward** the following CPT codes will require PA. Providers must submit an outpatient PA request to CHNCT and obtain approval for the following services prior to providing them to HUSKY Health members and billing the Department.

- 58345 - transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography
- Q4110 - Primatrix, per square centimeter
- Q4115 - Alloskin, per square centimeter
- Q4116 - Alloderm, per square centimeter
- Q4121 - Theraskin, per square centimeter

Reimbursement for Select Manually Priced (MP) Services

Effective for dates of service January 1, 2015 and forward the following services, which were not previously priced by Medicare and as a result manually priced by the Department, will be reimbursed at a set maxfee amount. The maxfee amounts were set based on the 2015 Medicare fee schedule and the applicable physician reimbursement policy.

- 90661 - Flu vacc cell cult prsv free
- 95943 - Parasymp&symp hrt rate test

- 97610 - Low frequency non-thermal us
- A9575 - Inj gadoterate meglumi 0.1ml
- J1446 - Inj tbo-filgrastim 5 mcg
- J1602 - Golimumab for iv use 1mg
- J7180 - Factor xiii anti-hem factor
- J9371 - Inj vincristine sul lip 1mg
- Q4121 - Theraskin
- 15847 - Exc skin abd add-on
- 32855 - Prepare donor lung single
- 32856 - Prepare donor lung double
- 33933 - Prepare donor heart/lung
- 33944 - Prepare donor heart
- 34841 - Endovasc visc aorta 1 graft
- 34842 - Endovasc visc aorta 2 graft
- 34843 - Endovasc visc aorta 3 graft
- 34844 - Endovasc visc aorta 4 graft
- 34845 - Visc & infraren abd 1 prosth
- 34846 - Visc & infraren abd 2 prosth
- 34847 - Visc & infraren abd 3 prosth
- 34848 - Visc & infraren abd 4+ prost
- 43252 - Egd optical endomicroscopy
- 43496 - Free jejunum flap microvasc
- 43647 - Lap impl electrode antrum
- 43648 - Lap revise/remv eltrd antrum
- 43881 - Impl/redo electrtd antrum
- 43882 - Revise/remove electrtd antrum
- 44137 - Remove intestinal allograft
- 44715 - Prepare donor intestine
- 47143 - Prep donor liver whole
- 47144 - Prep donor liver 3-segment
- 47145 - Prep donor liver lobe split
- 50323 - Prep cadaver renal allograft
- 50325 - Prep donor renal graft
- 65757 - Prep corneal endo allograft
- 76496 - Fluoroscopic procedure
- 76497 - Ct procedure
- 76498 - Mri procedure

Modifier 59

Effective January 1, 2015, the Centers for Medicare and Medicaid Services (CMS) is implementing four new HCPCS modifiers as a subset of modifier 59, "Distinct Procedural Service". The new subset of modifiers should be used in lieu of modifier 59, when appropriate, to provide greater reporting specificity. These new modifiers will provide a better description of the reason that the provider considers the procedure to be separate and distinct. The four new modifiers are:

- **XE- Separate Encounter** - A service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.
- **XS- Separate Structure** - A service that is distinct because it was performed on a separate organ/structure.
- **XP- Separate Practitioner** - A service that is distinct because it was performed by a different practitioner.

- **XU- Unusual Non-Overlapping Service** - The use of a service that is distinct because it does not overlap usual components of the main service.

Like CMS, the Department will continue to recognize modifier 59 after January 1, 2015; however, note that the Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. For more information, please go to the CMS NCCI Web site: <http://www.cms.gov/NationalCorrectCodInitEd/>.

Reimbursement for Practitioner Services Rendered in a Facility Setting

Effective for dates of service **January 1, 2015 and forward**, the Department will establish rates based on the facility type code (FTC) / place of service (POS) code in which the service is rendered for the following 17 codes.

- 99201 – 99215 – Office or Other Outpatient Service
- 99291 – 99292 – Critical Care Services
- 99354 – 99355 – Prolonged Services
- 99406 – 99407 – Smoking and Tobacco Use Cessation
- 99461 – Newborn Care Services

As communicated in PB 2014-60, effective 10/1/14, the Department adjusted reimbursement for practitioners and established a lower facility rate for specific services. This policy change was implemented in order to align Medicaid practitioner reimbursement more closely with Medicare and to ensure that the Department does not reimburse both the professional provider and the facility for the overhead and similar charges incurred only by the facility. The 17 codes listed above were not included in this update in order for the Department to remain in compliance with Section 1202 of the Affordable Care Act (Increased Payments for Primary Care). However, since Section 1202 of the Affordable Care Act sunsets on December 31, 2014, the Department will establish rates specific to the FTC/POS in which the service is rendered for the 17 codes listed above.

As a reminder the Department defines facility as the following FTC / POS codes:

- 21 – Inpatient Hospital
- 22 – Outpatient Hospital
- 23 – Emergency Room
- 24 – Ambulatory Surgical Center
- 25 – Birthing Center
- 31 – Skilled Nursing Facility
- 32 – Nursing Facility

All of these policy changes apply to services reimbursed under HUSKY Health (HUSKY A, B, C

and D) for dates of service January 1, 2015 and forward, unless otherwise noted.

For questions about billing or if further assistance is needed to access the fee schedule on the Connecticut Medical Assistance Program Web site, please contact the HP Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

Posting Instructions: Policy transmittals can be downloaded from the Connecticut Medical Assistance Program Web site at www.ctdssmap.com.

Distribution: This policy transmittal is being distributed to holders of the Connecticut Medical Assistance Program Provider Manual by HP Enterprise Services.

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