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Connecticut Medical Assistance Program

Policy Transmittal 2011-17

PB-2011-73
September 2011

Roderick L. Bremby, Commissioner

Effective Date: November 1, 2011
Contact: Barbara Fletcher @ 860-424-5136

TO: Physicians, Advanced Practice Registered Nurses (APRN), Certified Nurse Midwives (CNM), Clinics, Independent Labs, Independent Radiologists, Home Health Agencies, Outpatient Hospitals and Pharmacies

RE: New Tuberculosis Eligibility Group and Changes to the Home Health Fee Schedule

The purpose of this Policy Transmittal is to inform affected providers that the Department is establishing a new eligibility group for individuals with tuberculosis (TB) effective November 1, 2011. The eligibility group provides coverage for TB-related services for those with TB who are not otherwise eligible for Medicaid. Clients eligible for the new group will receive a standard gray Connect Card.

CURRENT PROVIDERS

Physicians, advanced practice registered nurses, certified nurse midwives, clinics, independent labs, independent radiologists, and outpatient hospitals may bill for procedures on their individual fee schedules that are related to a TB diagnosis. The Department has identified the following ICD-9 diagnoses as TB related: 010 – 018.96, 771.2, 137 – 137.4, 647.3 – 647.34 and 795.51 – 795.52.

The home health agency fee schedule is being expanded to include a new code G0163-"Skilled nursing services of a licensed nurse…in the delivery of observation and assessment of the patient's condition", also known as "Direct Observed Therapy" (DOT). This code may be used for current Medicaid clients as well as the new eligibility group. Home health agencies may bill this code for clients receiving DOT when ordered by a physician. The fee for this code is $58.76. The primary diagnosis must be TB. No other codes on the home health fee schedule are payable for the TB coverage group. DOT may not be billed on the same date of service as a skilled nursing visit or a medication administration visit.

Limited pharmacy coverage is included for the new TB eligibility group. A select group of drugs that are relevant to the treatment of TB will be covered when an ICD-9 diagnosis of TB is present on the prescription and submitted on the pharmacy claim. These drugs include select antibacterials, antimycobacterials, antimicrobials, and steroids/anti-inflammatory agents. A comprehensive list of payable drugs will be available at www.ctdssmap.com on or after October 15, 2011. From the Home page, go to Pharmacy Information→Pharmacy Program Publications→TB Drug List. This list will be updated as needed.

Any provider who identifies an individual not eligible for Medicaid who has active or latent TB is encouraged to refer the client to the Department of Social Services Adult Support Unit at (860) 424-5250 for eligibility determination. The Department will mail a paper application to the individual which must be completed and sent back to Adult Services, 10th floor, Department of Social Services, State of Connecticut, 25 Sigourney St, Hartford, CT 06106-5033 or faxed to (860) 424-4957.

CLIENT ELIGIBILITY VERIFICATION

The HP Automated Eligibility Verification System will return client information that identifies if a client is eligible for the new TB coverage group. Coverage is provided for both active TB patients and those with latent TB infection. The eligibility verification response for this population will be "Tuberculosis Covered Services Only".

BILLING INSTRUCTIONS

For providers billing on the professional claim form (physicians, APRNs, CNMs, clinics, independent labs, and independent radiologists) the detail diagnosis code pointer must point to a TB diagnosis for each of the detail procedure codes billed.

Providers billing on the institutional claim form (outpatient hospitals and home health agencies) must indicate in the header that the primary diagnosis is TB. If a home health agency is billing for some services unrelated to TB as well as DOT, they must submit a split claim with the DOT on one claim showing primary diagnosis of TB and other services on a separate claim with the appropriate diagnosis code.

For pharmacy claims a primary diagnosis code of TB is required to be submitted in the NCPDP field 494-DO. If a particular NDC requires a specific diagnosis code, that diagnosis code and a TB related diagnosis code must both be present for the claim to pay.

For questions about billing or claims processing, 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 or locally in the Farmington, CT area at (860)-269-2028.

LOCAL HEALTH DEPARTMENTS

In order to facilitate ongoing provision of necessary services to clients diagnosed with TB, the Department is enrolling local health departments as a new provider type. Payment to local health departments will be limited to a select group of codes essential for the diagnosis, treatment and management of a client diagnosed with TB. The fee schedule and billing instructions have been posted to the DSS Web site www.ctdssmap.com. The fee schedule can be found under Provider→Provider Fee Schedule Download→ Special Services. Billing instructions are located in Chapter 8 of the Provider Manual under Special Services. The Connecticut Department of Public Health will work with DSS to facilitate enrollment of local health departments.

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. Managed Care Organizations are requested to send this bulletin to their network providers and subcontractors.

Responsible Unit: DSS, Medical Care Administration, Medical Policy Section, Barbara Fletcher (860) 424-5136

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