Connecticut Medical Assistance Program Provider Bulletin 2016-97
Policy Transmittal 2016-39 December 2016

Effective Date: January 1, 2017
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TO: Physicians, Physician Assistants, Advanced Practice Registered Nurses, Certified Nurse Midwives, Podiatrists, Optometrists and Oral Surgeons

RE: (1) 2017 HIPAA Compliant Update
(2) Changes to the Reimbursement of Select Services
(3) Addition and Removal of Services

Effective for dates of service January 1, 2017 and forward, the Department of Social Services (DSS) is incorporating three changes into the Physician Office and Outpatient, Physician Surgical and Physician Radiology Fee Schedules. These changes include: (1) the 2017 Health Insurance Portability and Accountability Act (HIPAA) Compliant Update, (2) Changes to the Reimbursement of Select Services, and (3) Addition and Removal of Select Services.

(1) HIPAA Compliant Update

Effective for dates of service January 1, 2017 and forward, the Department is incorporating the 2017 HIPAA compliant update (code additions, deletions and description changes) within the Physician Office and Outpatient, Physician Surgical, and Physician Radiology Fee Schedules. The Department is making these changes to ensure that the Physician Fee Schedules remain compliant with the HIPAA.

The following provides a high level overview of particular 2017 HIPAA compliant changes of which providers should make note. This is not an exhaustive list of the HIPAA compliant changes and instead notes specific changes to codes and categories of service that are frequently utilized. Providers are encouraged to review the updated Physician Fee Schedules for all of the 2017 HIPAA compliant changes. Updated Fee Schedules will be available for review after December 23, 2016.

Maternal Depression Screens

As part of the 2017 HIPAA compliant update, procedure code 99420 is being deleted and replaced with the following codes:

Procedure Code	Description
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument)
96161	Administration of care-giver focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation

Procedure codes 96160 and 96161 will be added to the Physician Office and Outpatient Fee Schedule and will be reimbursable for **only maternal depression screens**. Procedure code 96161 should be utilized when the maternal depression screen is administered by a pediatric provider to the mother of their pediatric patient. All other providers should use procedure code 96160.

Reimbursement for maternal depression screens will be maintained at $18.00. Please refer to Provider Bulletin 2016-63 "Maternal Depression Screenings" for additional information. This provider bulletin replaces procedure code 99420 with the codes listed above. All other information

contained within PB 2016-63 remains valid and effective for maternal depression screens.

Mammography Coding Changes

Effective January 1, 2017 and forward the coding for screening and diagnostic mammography will change. As outlined below, instead of billing for the computer aided detection (CAD) service as a separate add-on procedure code, CAD will be included in the description for the screening and diagnostic mammography codes.

Procedure Code	Description
77065	Diagnostic mammography, **including computer-aided detection (CAD)**, when performed; unilateral
77066	Diagnostic mammography, **including computer-aided detection (CAD)**, when performed; bilateral
77067	Screening mammography, bilateral (2-view study of each breast) **including computer-aided detection (CAD)**, when performed

Since Medicare does not price the revised mammography codes, the current Medicaid payment rates for the screening and diagnostic mammography codes and the add-on codes for the CAD service are added together to set the payment rates for each of the respective 2017 mammography codes and modifier combinations.

Physical and Occupational Therapy Evaluations

New physical and occupational therapy codes have been created for 2017 to provide the ability to identify the level of complexity and specificity with regards to the patient's history and clinical presentation, as well as the level of decision making required by the provider. Please consult the Current Procedural Terminology (CPT) manual for the new procedure codes and the guidelines to use in the selection of the most appropriate procedure code.

Moderate Sedation Coding

Multiple changes have been included in the description and coding for moderate sedation services, including the creation of a new set of procedure codes for moderate sedation and the removal of the designation that specific services inherently include moderate sedation services. Providers are encouraged to review the CPT manual guidelines on how to select and code the new moderate sedation procedure codes.

(2) Changes to the Reimbursement of Select Services

Effective for dates of service January 1, 2017 and forward the reimbursement for procedure codes 67227 and 67228 will be revised to account for the change in the description of the services that allows for billing for more than one session.

Procedure Code	Description	Rate Type	2017 Rate
67227	Destruction of extensive or progressive retinopathy, cryotherapy, diathermy	SUR FTS	$183.11 $161.90
67228	Treatment of extensive or progressive retinopathy, photocoagulation	SUR FTS	$214.76 $193.32

**Please refer to PB 2014-60 for more information on services reimbursed under the FTS versus the SUR rate types.*

Additionally for dates of service January 1, 2017 and forward the following physician administered drugs and immunoglobulins services will be revised to the 2017 Medicare Average Sales Price (ASP) rate, the wholesale acquisition cost, or for 90384-90386, the estimated acquisition cost (EAC) for each specific national drug code (NDC). The EAC rate is equal to average wholesale price (AWP) – 16.5%.

Procedure Code	Description	2017 Rate
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)	$858.33
J0585	Injection, onabotulinumtoxin A	$5.94
J0586	Abobotulinumtoxin A	$7.80
J7307	Etonogestrel implant (Nexplanon)	$847.90
J0897	Xgeva	$16.52
J2788	Injection, Rho D immune globulin, human, minidose, 50 mcg	$25.29
J2790	Injection, Rho D immune globulin, human, full dose, 300 mcg (1500 IU)	$80.19
J2791	Injection, Rho D immune globulin (human), (Rhophylac), intramuscular or intraveneous, 100 IU	$4.79
J2792	Injection, Rho D immune globulin, intravenous, human, solvent detergent, 100 IU	$22.32
90384	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use	EAC
90385	Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use	EAC
90386	Rho(D) immune globulin (RhIgIV), human, for intravenous use	EAC

(3)<u>Addition and Removal of Select</u> Services

<u>Addition of Select Services</u>

Effective for dates of service January 1, 2017 and forward, the following services will be added to the applicable physician fee schedule.

Procedure Code	Description	2017 Rate
S5001	Prescription drug, brand – to be used in combination with the NDC for Truvada	EAC
55970	Intersex surgery; male to female	Manually Priced
55980	Intersex surgery; female to male	Manually Priced

<u>Truvada</u>:

Procedure code S5001 is already listed as a payable code on the physician office and outpatient fee schedule, but effective January 1, 2017, S5001 can be used in combination with the NDC for Truvada to bill for pre-exposure prophylaxis medication Truvada. Providers must submit the detail for Truvada with the applicable NDC and the NDC units. The detail will reimburse the EAC for the specific NDC billed. Truvada will be payable under the family planning limited benefit program in addition to HUSKY A, B, C, and D.

Intersex Surgery Codes – Gender Reassignment Surgery:

Procedure codes 55970 and 55980 are being added to the physician surgical fee schedule in order to capture more accurate data for analytic purposes. Intersex surgery services are currently covered and reimbursed as manually priced services under different "unlisted" procedure codes related to the genital regions as specified under PB 2016-66. This policy transmittal replaces the procedure codes listed in PB 2016-66 and requires the use of **55970 or 55980** instead of 55899 or 58999 and requires the use of diagnosis code **F64.0** instead of F64.1 effective January 1, 2017. All other content of PB 2016-66 remains valid and effective for submitting for gender reassignment procedures and surgery.

Effective January 1, 2017 and forward providers must submit prior authorization (PA) requests with **55970** or **55980** and must continue the list of applicable procedure code(s) for each component to be performed as part of the overall gender reassignment surgery. Although the prior authorization will be submitted with procedure 55970 or 55980 AND each individual procedure code that will be performed as part of the overall surgical procedure; claims should be submitted with only procedure code **55970** or **55980.** Claims must also be submitted with the diagnosis code **F64.0** "Transsexualism". Providers are reminded to bill their usual and customary charges.

Please note that any PA request submitted for gender reassignment (prior to 1/1/2017) under procedure codes 55899 or 58999 or a PA request already approved under 55899 or 58999 (even if the service will occur after 1/1/2017) will be honored and providers do not need to submit a new PA request under the revised coding.

Removal of Select Services

Effective for dates of service January 1, 2017 and forward the Department is removing the following procedure codes from the physician fee schedule:

Procedure Code	Description
99380	Physician supervision of a nursing facility patient (patient not present); 30 minutes or more
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form
90476	Adenovirus vaccine type 4
90477	Adenovirus vaccine type 7

These services are being removed (1) to ensure that the codes listed are supported by current policy, (2) to maintain a fee schedule that is consistent and account for lack of utilization of services, and (3) to account for current indications of use for services (i.e., adenovirus indications are specific to military personnel). Details on claims submitted with one of the procedure codes listed above for dates of service January 1, 2017 and forward will deny.

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 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 by Hewlett Packard Enterprise to providers enrolled in the Connecticut Medical Assistance Program.

Responsible Unit: DSS, Division of Health Services, Medical Policy Section; Dana

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