**Connecticut Medical Assistance Program**
Policy Transmittal 2015-48

Provider Bulletin 2015-97
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Roderick L. Bremby, Commissioner

Effective Date: January 1, 2016
Contact: Nina Holmes @ 860-424-5486

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

RE: (1) 2016 HIPAA Compliant Update
(2) Establishing Maxfees for Select Services
(3) Removal and Addition of Select Services
(4) Place of Service Codes

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Effective for dates of service January 1, 2016 and forward, the Department of Social Services is incorporating four changes into the physician office and outpatient, physician surgical and physician radiology fee schedules. These changes are (1) the 2016 HIPAA Compliant update, (2) establishing maxfees for select services, (3) removing and adding select services and (4) updating place of service codes (POS) 19 and 22.

**(1) HIPAA Compliant Update**

Effective for dates of service **January 1, 2016 and forward**, the Department is incorporating the 2016 HIPAA compliant update 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 Health Insurance Portability and Accountability Act.

As part of the HIPAA compliant update, procedure code J7302 (Levonorgestrel iu 52 mg) is being discontinued and replaced by J7297 (Levonorgestrel iu 52mg 3 yr) that is to be used for the Liletta intrauterine device and J7298 (Levonorgestrel iu 52mg 5 yr) that is to be used for the Mirena intrauterine device. Effective for dates of service January 1, 2016 and forward, providers should submit claims with the appropriate procedure code to distinguish billing for Liletta versus Mirena.

The following Category I Current Procedural Terminology (CPT) codes although new services effective for 2016 will **not** be reimbursable under the Connecticut Medical Assistance Program (CMAP):

- Prolonged Clinical Staff Services (CPT 99415 – 99416) will not be reimbursed under CMAP because services rendered by clinical staff, as defined in the CPT manual, are not eligible for reimbursement under the Regulations Concerning Physicians' Services (Sections 17b-262-337 to 17b-262-349 of the Regulations of Connecticut State Agencies). The Department will continue to reimburse for medically necessary prolonged service with direct patient contact that is provided by a physician or allied health professional as defined under Section 17b-262-338 (4) of the Regulations of Connecticut State Agencies.

- Reflectance Confocal Microscopy for cellular and subcellular imaging of skin (CPT Codes 96931-96936) will not be reimbursed under CMAP at this time due to limited empirical data substantiating the efficacy of its use. The Department will monitor the literature regarding this technology and will consider addition of this service at a future date. Providers will be notified via a policy transmittal if the Department adds the service.

**(2) Establishing Maxfees for Select Services**

The following services, which were not previously priced by Medicare and as a result manually priced by the Department, will now have a maxfee amount set based on the published 2016 Medicare Physician Fee Schedule rate, effective for dates of service January 1, 2016 and forward. The maxfee amounts were set at 57.5% of the 2016 Medicare Physician fee schedule rate.

- 97607 - Neg press wnd tx </=50 sq cm
- 97608 - Neg press wound tx >50 cm
- 92921 - Prq cardiac angio addl art
- 92929 - Prq card stent w/angio addl
- 92934 - Prq card stent/ath/angio
- 92938 - Prq revasc byp graft addl
- 44401 - Colonoscopy with ablation
- 44402 - Colonoscopy w/stent plcmt
- 44403 - Colonoscopy w/resection
- 44404 - Colonoscopy w/injection
- 44405 - Colonoscopy w/dilation
- 44406 - Colonoscopy w/ultrasound
- 44407 - Colonoscopy w/ndl aspir/bx
- 44408 - Colonoscopy w/decompression
- 45346 - Sigmoidoscopy w/ablation
- 45347 - Sigmoidoscopy w/plcmt stent
- 45349 - Sigmoidoscopy w/resection
- 45350 - Sgmdsc w/band ligation

**(3) Removal and Addition of Services**

Effective for dates of service January 1, 2016 and forward the Department is removing procedure code 96376 from the physician fee schedule. CPT guidelines specify that this service may only be reported by facilities.

Also effective for dates of service January 1, 2016 and forward the following procedure codes, that are not new for 2016 but were not previously payable under CMAP, will be added to the applicable physician fee schedule:

Physician Office and Outpatient

- 90630 – Influenza virus vaccine, quadrivalent (iiV4), split virus, preservative free, for intradermal use
- J7508 – Tacrolimus, extended release, oral, 0.1 mg

Physician Radiology

- 77061 Digital breast tomosynthesis; unilateral
- 77062 – Digital breast tomosynthesis; bilateral
- 77063 – Digital breast tomosynthesis screening; bilateral

**(4) Place of Service Codes**

Effective for dates of service January 1, 2016 and forward the Department is adding place of service (POS) code 19 (Off Campus-Outpatient Hospital) and revising the description of POS code 22 to On Campus-Outpatient Hospital. POS 19 will be added to all services that are currently eligible for reimbursement in POS 22.

As outlined in PB 2014-60, POS 19 (Off Campus-Outpatient Hospital) represents a facility, therefore applicable services performed in POS 19 will be reimbursed at the corresponding facility setting rate (rate types FTD, FTM, FTP, FTO, FTS, or FTL). Please refer to PB 2014-60 for more details regarding reimbursement for practitioner services rendered in a facility setting.

**Accessing the Fee Schedules**

Fee schedules can be accessed and downloaded by going to the Connecticut Medical Assistance Web site: www.ctdssmap.com. From this Web page, go

to “Provider”, then to “Provider Fee Schedule Download”, click on the “I accept” button and then locate the appropriate Physician Fee Schedule. To access the CSV file, press the control key while clicking the CSV link, then select “Open”. The “Fee Schedule Instructions” link is available at the top of the fee schedule page.

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.

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