Connecticut Medical Assistance Program
Policy Transmittal 2020-67

Provider Bulletin 2020-102
January 2021

Deidre S. Gifford, MD, MPH, Commissioner

Effective Date: January 1, 2021
Contact: colleen.johnson@ct.gov

TO: Independent Laboratories and Outpatient Hospitals

RE: CMAP COVID-19 Response – Bulletin 47: Updated Billing Guidance Regarding High-Throughput Technology Billed Under Procedure Codes U0003 and U0004

Effective for dates of service January 1, 2021 and forward, the Department of Social Services (DSS) will update the reimbursement for clinical diagnostic laboratory tests (CDLTs) for the detection of SARS-CoV2 or for the diagnosis of the virus that causes COVID-19 when using high-throughput technologies consistent with the modified guidance published by the Centers for Medicare and Medicaid Services (CMS) in Ruling 2020-1-R2. The CMS ruling can be accessed by clicking the following link: https://www.cms.gov/files/document/cms-ruling-2020-1-r2.pdf.

Consistent with the guidance issued in the CMS Ruling 2020-1-R2, effective January 1, 2021, DSS will implement the following reimbursement updates for CDLTs that utilize high-throughput technology:

- Reimbursement for high throughput tests billed with procedure codes U0003 and U0004 will be priced at $75.00; and

- Add-on procedure code U0005 will be added to the laboratory fee schedule and priced at $25.00. The add-on code U0005 was created to be billed in combination with procedure codes U0003 or U0004 only when providers meet the specific criteria outlined by CMS. See the section titled Add-on Code U0005 Criteria and the CMS Ruling 2020-1-R2 for more information on when to bill with add-on code U0005.

Codes	Description	Rate	Effective Date
U0003	Cov-19 amp prb hgh thruput	$75.00	1/1/2021
U0004	Cov-19 test non-cdc hgh thru	$75.00	1/1/2021
U0005*	Infec agen detec ampli probe	$25.00	1/1/2021

**Providers must meet specific criteria in order to bill procedure code U0005*

Add-on Code U0005 Criteria

As specified in the CMS 2020-1-R2 guidance, the following criteria **must** be used to determine when to bill with U0005. If the criteria below are met, procedure code U0005 can be billed and will reimburse $25.00 in addition to the $75.00 for U0003 or U0004 resulting in a total payment of $100.00 for the high-throughput testing.

1. The applicable CDLTs billed under U0003 or U0004 is completed within 2 calendar days of the specimen being collected (this means that the results of the test are finalized and ready for release within 2 calendar days); **and**
2. The majority (51%) of COVID-19 CDLTs were performed using high throughput technology in the previous calendar month were completed in 2 calendar days or less for all their patients (not just for Medicare patients).

Providers should assess their performance based on CDLTs making use of high throughput technologies completed during the

calendar month that precedes the month identified by the CDLT detail date of service

prior to claims submission to determine if such performance meets the criteria outlined above. For providers that did not complete 51% of their COVID-19 CDLTs (for all patients) within two (2) calendar days, which includes the finalization and release of results, those providers may **not** bill procedure code U0005 and are **not** eligible for the $25.00 add-on payment. Payment for CDLTs for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that do not meet criteria in the preceding calendar month will receive $75.00.

Documentation Specific to High-Throughput Testing

Providers must maintain documentation to demonstrate compliance with the requirements of the CMS 2020-1-R2 ruling for billing procedure code U0005. DSS may request a copy of this documentation during post payment reviews.

As a reminder, as specified in Section 17b262-649 of the Regulations of Connecticut State Agencies concerning Independent Laboratory Requirements for Payment of Independent Laboratory Services, payment shall be made at the lowest of (1) the providers usual and customary charge to the general public; (2) the lowest Medicare rate; (3) the amount in the applicable fee schedule as published by the Department; (4) the amount billed by the provider; or (5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

Outpatient Hospitals

The procedure codes listed above that have been added to CMAP's laboratory fee schedule have been added to CMAP's Addendum B. Outpatient Hospitals should continue to follow CMAP Addendum B for coverage and payment of all outpatient hospital services.

Accessing the Fee Schedule:

The updated fee schedule can be accessed and downloaded by accessing the Connecticut Medical Assistance Program (CMAP) 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 proceed to click on the appropriate fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open".

For questions about billing or if further assistance is needed to access the fee schedule on the CMAP 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 Web site at www.ctdssmap.com.

Distribution: This policy transmittal is being distributed to providers of the Connecticut Medical Assistance Program by Gainwell Technologies.

Responsible Unit: DSS, Division of Health Services, Medical Policy Section; Colleen Johnson, Health Program Assistant, email colleen.johnson@ct.gov

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