Connecticut Medical Assistance Program

PB 2012-69

Policy Transmittal 2012-26

December 2012

Roderick L. Bremby, Commissioner

Effective Date: January 1, 2013

TO: Physicians, Physician Assistants, Advance Practice Registered Nurses (APRN), Nurse-Midwives, Podiatrists, Optometrists and Oral Surgeons

RE: (1) Incorporation of the January 2013 HCPCS Changes
(2) Additional Modifiers
(3) Psychotherapy Changes for 2013
(4) ACA Increased Payments for Medicaid Primary Care Services

(1) Incorporation of the January 2013 HCPCS Changes

Effective for dates of service January 1, 2013 and forward, the Department of Social Services is incorporating the applicable 2013 HCPCS additions, deletions and description changes into its Physician Fee Schedules under the HUSKY Health program. The HUSKY Health program includes HUSKY A, HUSKY B, HUSKY C, HUSKY D and the Charter Oak programs.

The Department is making these changes to ensure that its Physician Fee Schedules remain compliant with the Health Insurance Portability and Accountability Act.

(2) Additional Modifiers

CMS has established two new anatomical modifiers that must be used to designate the part of the body on which the procedure is performed in order for multiple units to pay. Use of these modifiers will bypass the NCCI editing. The two modifiers are:

Modifier	Anatomical designation
LM	Left main coronary artery
RI	Ramus intermedius coronary artery

A complete list of the modifiers and modifier indicators as well as additional guidance for billing with these modifiers can be found on the CMS website at http://www.cms.gov/NationalCorrectCodInitEd/.

(3) Psychotherapy Changes

There have been significant changes to the procedure codes used for psychiatric diagnostic evaluations, pharmacological management (with no more than minimal psychotherapy) and some of the psychotherapy services. Please carefully review the procedure codes and be sure to use them in a HIPAA compliant manner. Providers must maintain documentation to support each service for which they bill.

Psychotherapy Fees:

Whenever new codes are added there is a challenge to price them in a way that is fair to the providers while remaining fiscally neutral for the state. This year is no exception. At times there is a single code being added that corresponds to a single code being deleted. For example, 90834: "Psychotherapy 45 minutes" is an approximate replacement for 90806 "Individual psychotherapy….approximately 45-50 minutes". In these circumstances, the replacement code is being priced at the rate on the 2012 Medicaid fee schedule of the code it most closely approximates.

However, when medical services are part of the encounter, two codes might now be billed where only one code was billed previously. For example for services provided by an MD or APRN, an appropriate Evaluation & Management code plus the new add-on code 90833 "30 minute psychotherapy when performed with an evaluation and management service" may now be billed for what previously was billed as a 90805. In these circumstances, the aggregate payment for the two codes will be capped at the 2012 Medicaid fee schedule amount for the deleted psychotherapy code. The table below outlines the EOB number and description providers will receive whenever the capped amount is set.

EOB #	EOB Description
6705	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED
6706	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED
6712	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED
6713	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED
6718	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED

6719	PROCEDURE CODE COMBINATION REDUCED TO MAXIMUM ALLOWED

Prior Authorization for Psychotherapy Services:
Existing prior authorizations already received by providers for routine outpatient psychiatric services which will span the transition to the new outpatient psychiatric procedure codes will be honored for those services. Providers will not need to modify any existing authorizations.

Effective for dates of service January 1, 2013 and until otherwise notified by the department prior authorization will be suspended for the following psychotherapy services when provided by independent psychiatrists, psychiatric APRNs and doctors of osteopathy.

Code	Description
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service
99201-99205	Office or other outpatient visits for new patients
99211-99215	Office or other outpatient visits for established patients

The department will notify providers before reestablishing the prior authorization requirements to the above services. **Please note all other psychotherapy services will continue to require prior authorization.** For more information about prior authorization for behavioral health/psychotherapy services providers should contact CTBHP at 1-877-552-8247.

(4) ACA Increased Payments for Medicaid Primary Care Services

Pursuant to section 1202 of the Affordable Care Act the Department is in the process of analyzing and implementing the provisions outlined in the Federal Final Rule for Increased Payments for Medicaid Primary Care Services. This mandate provides reimbursement at 100% of the Medicare rate for eligible pediatric, internal medicine and family medicine providers for calendar years 2013 and 2014. Primary care services eligible for increased payments include currently payable services identified by CPT codes 99201-99499 and vaccine administration codes 90460, 90471-90474.

Given that the Final Rule was not released until November and that the department must complete the state plan amendment process prior to implementation, the Department anticipates implementation of all the necessary changes to occur no earlier than July 1, 2013. All changes will be implemented retroactive to dates of service January 1, 2013 and HP will automatically identify and reprocess the necessary claims. Please stay tuned as the Department will provide more information regarding Increased Payments for Medicaid Primary Care Services over the next few months.

Accessing the Fee Schedule:
The updated fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program Web site: www.ctdssmap.com. From this web page, go to "Provider", then to "Provider Fee Schedule Download", then to the appropriate "Physician" 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 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: Holders of the Connecticut Medical Assistance Program Provider Manual should replace their existing fee schedule with the new schedule. Policy transmittals can also 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.

Responsible Unit: For questions related to medical services: DSS, Division of Health Services, Medical Policy Section; Nina Holmes, Policy Consultant, (860) 424-5486.

For questions related to behavioral health (psychotherapy) changes: DSS, Division of Health Services, Behavioral Health Unit; Paul Piccione, PhD, (860) 424-5160.

Date Issued: December 2012