Connecticut Medical Assistance Program PB 2013-44
Policy Transmittal 2013-20 August 2013

Roderick L. Bremby, Commissioner
Effective Date: November 1, 2013
Contact: Barbara Fletcher @ 860-424-5136

TO: General Hospitals

RE: Claims for Outpatient Surgery and Pathology Lab Services

Effective November 1, 2013, the Department of Social Services will require hospitals to bill all laboratory services, including RCCs 310-319 (laboratory-pathology) as well as 300-309 (laboratory-clinical diagnostic), and outpatient surgery (RCCs 490, 499, 360, 361 and 369) with the Revenue Center Code (RCC) plus the appropriate CPT code(s).

Laboratory-Pathology: RCCs 310-319

As directed by the Office of the Inspector General in a recent audit, the Department will require all outpatient hospital providers to bill for RCCs 310-319 (lab pathology) with a CPT code in the same manner as hospitals currently bill for RCCs 300-309 (lab-clinical diagnostic). Effective November 1, 2013, payment for tests billed under RCCs 310-319 will be either at the fee listed on the consolidated lab fee schedule or remain as a cost to charge ratio. For those tests where Medicare pays under the APC payment methodology the Department will pay as a cost to charge ratio. For those tests which are paid under Medicare's Clinical Lab Fee schedule the Department will pay the fee listed on the Department's consolidated lab fee schedule.

Please check the following link to determine if the RCC + CPT combination will be paid off the Department's Consolidated Lab Fee schedule or as a ratio of costs to charges. Click on "January 2013 Addendum B"; then "Addendum B" again; then "January 2013 Web Addendum". If the status indicator (SI) is "X" the RCC+CPT combination will pay as a ratio of costs to charges; if the status indicator is any value other than "X" (such as "A", "N" or "E") the RCC+CPT combination will pay off the Consolidated Lab Fee Schedule. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

Outpatient Surgery: RCCs 490, 499, 360, 361 and 369:

In order to promote more uniform payment across hospitals, effective November 1, 2013, the Department will require outpatient hospitals to submit both the RCC and supporting CPT code(s) when billing for RCCs 490, 499 (Ambulatory Surgical Care), 360, 361 and 369 (Operating Room Services). Payment will be made based on the fee for the CPT code as listed on the DSS Ambulatory Surgical Center fee schedule. The Ambulatory Surgical Center fee schedule will be expanded to include most outpatient surgical procedures performed by outpatient hospitals and billed to Medicare. Fees will be set at 100% of the 2012 Medicare fee. This policy applies to all outpatient surgical procedures performed in an outpatient hospital setting regardless of whether there is a separately identifiable cost center and regardless of whether the procedure is performed in the main hospital, another area of the hospital or another building not physically connected to the hospital.

DSS will make a single payment to the hospital for outpatient surgical procedures billed with RCCs 490, 499, 360, 361 and 369. This payment will include facility services that are considered inclusive to or bundled in the covered surgical procedure. Facility services which are considered inclusive to the covered surgical procedure include, but are not limited to:

- Use of the facility including nursing and technical personnel;
- Drugs, biologicals, supplies and dressings for which separate payment is not allowed under the Medicare Outpatient Prospective Payment System (OPPS);
- Materials, including supplies and equipment, for the administration and monitoring of anesthesia;
- Implantable devices for which separate payment is not allowed under OPPS;
- Facility services such as anesthesia (RCC 370) and Recovery Room (RCC 710); and
- Radiology services for which separate payment is not allowed under OPPS.

Separate payment may be made for covered ancillary services that are integral to a covered surgical procedure if separate payment is permitted under OPPS. The hospital may bill separately for these services. Ancillary services falling into this category include drugs, biologicals, radiology services and implantable devices. Ancillary services should be billed using the appropriate outpatient RCC (25x, 32x, 27x, etc.). A link will be created next to the ASC fee schedule titled, "T18 Outpatient Surgery/Ancillaries". The provider will click on the link and will need to review the tabs in the spreadsheet to determine which ancillary services should/should not be billed separately by the hospital.

The first tab (CY2012_ASC_FN_BB) lists ancillary services that are often billed in conjunction with outpatient surgery. If the payment indicator is N1 or L1 the service is included in the bundled payment for the ambulatory surgery procedure and should not be billed separately. If the payment indicator is H2, K2, Z2 or Z3 and there is a fee listed in the last column, the service may be billed in addition to RCC 490, 499, 360, 361 and 369. Payment will be at the usual rate for the appropriate RCC billed for that service by the outpatient hospital. If the service requires prior authorization (e.g. radiology) the hospital must secure such authorization before billing for the service. Otherwise the claim will deny. The second tab (CY2012_ASC_FN_DD1) is a key to the payment indicators.

For reference, the Ambulatory Surgery Center Fee Schedule Medicare MLN Fact sheet can be found at:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508-09.pdf

The Medicare claims processing manual for ASC can be found at:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf

Community-based physicians may continue to bill separately for the professional component of outpatient surgery and anesthesia services and will be paid based upon the fee listed in the physician fee schedule.

The Department will add RCCs 490 and 499 to the hospitals in Connecticut that do not currently have these RCCs on file effective November 1, 2013. No action is required on the part of the hospital.

Editing

Claims with RCC 490, 499, 360, 361 and 369 plus the supporting CPT code will be subject to National Correct Coding Initiative (NCCI) edits and the Department's bilateral and multiple surgery edits.

NCCI Edits

Please refer to PB 2010-57, PB 2011-12, PB 2011-41 and PB 2011-53 that fully explain the functionality of the NCCI edits. For easy reference, links to these bulletins are provided below:
https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=pb10_57.pdf&URI=Bulletins/pb10_57.pdf

https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=pb11_12revised2.pdf&URI=Bulletins/pb11_12revised2.pdf

https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=pb11_41revised2.pdf&URI=Bulletins/pb11_41revised2.pdf

https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=pb11_53.pdf&URI=Bulletins/pb11_53.pdf

Modifiers

Modifier 50 (bilateral procedure) must be used to report procedures that are performed on both sides of the body (mirror image) in the same operative session. For example, if CPT code 19318 (Reduction mammoplasty) is performed bilaterally, it must be billed on one line with modifier 50 (bilateral procedures) and one unit to denote that the procedure was performed on both sides of the client's body rather than billing two units of 19318. Bilateral procedures will be reimbursed at 150% of the fee on the Ambulatory Surgical Center fee schedule

Modifier 51 (multiple surgery) must be used whenever more than one procedure is performed. The hospital must always indicate the primary surgical procedure code on the first line of the claim and all additional surgical procedure codes on subsequent lines with modifier 51 (multiple surgery). All lines with modifier 51 will be paid at 50% of the fee on file for that procedure code. Subsequent surgical procedure billed without modifier 51 will deny.

Instructions for billing with modifiers has been added to Chapter 8 of the hospital manual.

Training

The Department has scheduled a webinar on September 26, 2013 for hospital billing staff in order to facilitate understanding of the billing requirements for pathology-lab and outpatient surgery RCCs.

Please visit www.ctdssmap.com to sign up for the Hospital Billing Changes Virtual Room Workshop on Thursday September 26, 2013 @ 1 PM – 3:30 PM. Once on the Home Page, go to Information, Publications and scroll down to Provider Workshop Invitation forms.

You may also enter this address into your browser to sign up for the Hospital Billing Changes Workshop. http://www.surveymonkey.com/s/HospitalBillingChangesWorkshop092613

Procedure Code 41899

The Department is adding procedure code 41899, "Unlisted procedure, dentoalveolar structures" to its ambulatory surgery fee schedule effective November 1, 2013. This code should be used by the hospital for dental surgeries that typically are performed in an office or clinic setting but because of the client's complex medical and/or behavioral needs the service must be performed in a facility setting. Procedure code 41899 represents the facility component of the service; dentists and oral surgeons should bill for the professional component of the service using procedure codes on the dental fee schedule. The maximum fee for the procedure is $1900.

Accessing the Fee Schedule:
The updated freestanding ambulatory surgery fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Website: www.ctdssmap.com. From this web page, go to "Provider", then to "Provider Fee Schedule Download", then to "Clinic-Ambulatory Surgery". 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: 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.

Responsible Unit: DSS, Division of Health Services, Medical Policy Section; Barbara Fletcher, Health Program Supervisor, (860) 424-5136.

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