Connecticut Medical Assistance Program Provider Bulletin IB19-36
Policy Transmittal 2019-12 May 2019

Roderick L. Bremby, Commissioner
Effective Date: June 1, 2019
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TO: Physicians, Advanced Practice Registered Nurses, Physician Assistants, Certified Nurse Midwives, Independent Laboratories, Independent Radiologists, Home Health Agencies, Outpatient Hospitals, Rehabilitation Clinics, Pharmacies and Local Health Departments

RE: Updating the Tuberculosis Limited Benefit

Effective November 11, 2011, the Department of Social Services (DSS) established an eligibility group for individuals diagnosed with tuberculosis (TB). This eligibility group provides coverage for TB-related services for those with TB who are not otherwise eligible for Medicaid.

This policy transmittal supersedes PB 11-73 "New Tuberculosis Eligibility Group and Changes to the Home Health Fee Schedule".

This policy transmittal (1) updates the guidance for billing for services under the TB Limited Benefit program and (2) outlines changes to the coding for direct observation therapy.

CLIENT ELIGIBILITY VERIFICATION:
The Automated Eligibility Verification System will return member information that identifies if a member is eligible for the TB Limited Benefit coverage group. Coverage is provided for both active TB patients and those with latent TB infection. The eligibility verification response for this population will be "Tuberculosis Covered Services Only".

TUBERCULOSIS DIAGNOSIS CODES:
DSS requires that a TB diagnosis code must be listed as the **primary** diagnosis code on all of the claims billing TB-related services. These select ICD-10 diagnosis codes are listed on Table 12: "Lists of ICD-10CM Diagnosis Codes for Tuberculosis Eligibility Waiver" under the "Fee Schedule Instructions" on the Connecticut Medical Assistance Program (CMAP) Web Page.

PROFESSIONAL PROVIDERS:
Physicians, advanced practice registered nurses (APRNs), certified nurse midwives (CNMs), rehabilitation clinics, independent laboratories, and independent radiologists may bill for procedures on their individual fee schedules that are related to a TB diagnosis.

HOME HEALTH AGENCIES:
Home health agencies may bill the appropriate procedure codes for "Direct Observed Therapy" (DOT). An enrolled physician must order DOT. No other procedure codes on the home health fee schedule are payable for this eligibility group covering TB-related services. DOT may not be billed on the same date of service as a skilled nursing visit or a medication administration visit.

LOCAL HEALTH DEPARTMENTS:
Local health departments (LHDs) can enroll as a provider type eligible to bill for TB-related services. Payment to local health departments is limited to a select group of procedure codes listed on the Special Services fee schedule under the rate type "TB". These procedure codes are essential for the diagnosis, treatment and management of individuals diagnosed with TB. The Special Services fee schedule and the billing instruction for the tuberculosis waiver program are posted on the DSS Web site,

www.ctdssmap.com. Billing instructions are located in Chapter 8 of the Provider Manual under Waiver Programs and Special Services.

PHARMACY COVERAGE:

Limited pharmacy coverage is included for this eligibility group covering TB-related services. A select group of drugs that are relevant to the treatment of TB will be covered when an ICD-10 **primary** diagnosis of TB is present on the prescription and submitted on the pharmacy claim. These drugs include select antibacterials, antimycobacterials, antimicrobials, and steroids/anti-inflammatory agents. A comprehensive list of payable drugs is available at www.ctdssmap.com. From the Home page, go to Pharmacy Information→Pharmacy Program Publications→ TB Drug Lists. The list will be updated as needed.

OUTPATIENT HOSPITALS:

Outpatient hospitals should continue to follow the Connecticut Medical Assistance Program's (CMAP's) Addendum B to determine the method of payment for all outpatient services. CMAP's Addendum B can be accessed via www.ctdssmap.com by selecting the "Hospital Modernization" Web page. Please see the section in this policy transmittal titled "Billing Instructions" and follow the guidelines for institutional billing.

Outpatient Hospitals–Professional Services:

Physicians, physician assistants, APRNs, and CNMs can provide TB-related services in the outpatient hospital setting. Providers rendering TB-related services in an outpatient hospital must follow the guidelines in this bulletin titled "Billing Instructions".

BILLING INSTRUCTIONS:

For providers billing on the professional claim (physicians, physician assistants, APRNs, CNMs, LHDs, rehabilitation clinics, independent laboratories, and independent radiologists) the detail diagnosis code pointer must point to a TB diagnosis that is listed on Table 12 of the fee schedule instructions for each of the detail procedure codes billed.

Effective for dates of service, June 1, 2019 and forward, the following HCPCS codes will be added to the home health agency fee schedule. These HCPCS codes will also be added to the special services fee schedule under the rate type "TB" to be billed by LHDs. HCPCS codes G0493 and G0494 should be billed for DOT services.

HCPCS Code	Description	Rate
G0493	Skilled Services By A Licensed Nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes	$58.78
G0494	Skilled Services By A Registered Nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes	$58.78

HCPCS codes G0493 and G0494 should be used for current HUSKY Health members diagnosed with TB and for individuals covered under the TB Limited Benefit eligibility group.

Providers billing on an institutional claim (outpatient hospitals and home health agencies) must indicate in the header that the **primary** diagnosis is TB. If a home health agency is performing DOT and other services that are not TB-related, they must submit a separate claim with the DOT showing primary diagnosis of TB. Home health agencies cannot bill DOT on the same day as skilled nursing services or medication administration services. Further, all other non-DOT services must be on a separate claim with the appropriate diagnosis code(s).

For pharmacy claims a primary diagnosis code of TB is required to be submitted in the NCPDP field 494-DO. If a particular NDC requires a specific diagnosis code, that diagnosis code and a TB related diagnosis code must both be present for the claim to pay.

FEE SCHEDULES:

Fee schedules can be accessed and downloaded from the CMAP Web site: www.ctdssmap.com. From the home page, go to "Provider", then to "Provider Fee Schedule Download". Click on the "I accept" button and proceed to 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 a 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 may be downloaded from the www.ctdssmap.com Web site.

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

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