MDHHS Michigan Department of Health & Human Services

Medical Services Administration BULLETIN MSA

Bulletin Number: MSA 18-01

Distribution: All Providers

Issued: January 30, 2018

Subject: Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Code Updates

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services

This bulletin is to notify you of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) changes being implemented by the Michigan Department of Health and Human Services (MDHHS). Effective dates are identified for each topic area. Please note that this notice is distributed to a broad range of providers and not all or any of the codes listed may apply to your scope of practice.

Refer to HCPCS code books and the Centers for Medicare & Medicaid Services (CMS) website (www.cms.hhs.gov) for full descriptions of codes. Information regarding fee screens is maintained on the appropriate database or professional fee schedule on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information. Additional pertinent coverage parameters, such as age restrictions, prior authorization requirements, and other billing indicators, are accessible via the Medicaid Code and Rate Reference tool within CHAMPS at https://sso.state.mi.us >> External Links >> Medicaid Code and Rate Reference.

A. JANUARY 1, 2018 ANNUAL HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODE UPDATES

Listed below are HCPCS codes being adopted by MDHHS for dates of service on and after January 1, 2018 and the provider groups allowed to bill these codes. Any new procedure code not listed will not be covered at this time, except for reporting codes. Coding information is based on the most recent file from CMS. If additional code revisions are released by CMS, a subsequent bulletin will be published notifying providers of this change.

The symbol * will appear with those codes requiring prior authorization (PA).

HCPCS 2018 reporting codes (Category II codes and other select HCPCS codes) will be allowed for submission to Medicaid where appropriate. The codes are optional but can be used to complement Category I codes for clarification purposes. Reporting codes will not appear on the MDHHS fee schedule; however, a full list of current codes can be found at www.ama-assn.org/go/cpt.

1. Physicians, Practitioners, and Medical Clinics

00731	00732	00811	00812	00813	15730	15733
19294	20939	31241	31253	31257	31259	31298
32994	33927*	33928*	33929*	34701	34702	34703
34704	34705	34706	34707	34708	34709	34710
34711	34712	34713	34714	34715	34716	36465*
36466*	36482*	36483*	38222	38573	43286	43287
43288	55874	58575	64912	64913	71045	71046
71047	71048	74018	74019	74021	81520*	81521*
86008	90756	94617	94618	95249	96573	96574
97763	99483	G0516*	G0517*	G0518*	J0565	J0606
J1555	J1627	J1726	J1729	J2326*	J2350*	J3358
J7210	J7211	J7296	J7345	J9022	J9023	J9203
J9285						

2. Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC)

MDHHS aligns with Medicare guidelines for procedure codes covered through the OPPS/APC as closely as possible. Certain procedures billed by Outpatient Hospitals, Comprehensive Outpatient Rehabilitation Facilities, Rehabilitation Agencies, and Freestanding Dialysis Centers may represent packaged/bundled service codes. The costs for these services are allocated to the APC but are not paid separately. For services not paid under OPPS, MDHHS will utilize a Medicare fee schedule with the MDHHS reduction factor applied.

a. Wrap Around Codes

MDHHS will cover the following codes differently (than Medicare) under its OPPS:

81247	81248	81249	81283	81328	81334	81335
81448	81541	81551	90756	99484	99492	99493
99494	0479T	0480T	0481T	0482T	0483T	0484T
0485T	0486T	0487T	0491T	0492T	0493T	0494T
0495T	0496T	0497T	0500T	0502T	0503T	C9748
G0511	G0512	G0513	G0514	J1428	J7296	L3761
L7700	P9073	P9100	Q2040	Q4176	Q4177	Q4178
Q4179	Q4180	Q4181	Q4182			

3. Ambulatory Surgical Centers (ASC)

MDHHS aligns with Medicare guidelines for Medicaid covered procedure codes covered through the Outpatient Ambulatory Prospective Payment System (OAPPS) as closely as possible. Certain procedures billed by ASCs may represent packaged/bundled service codes. The costs for these services are not paid separately. For ASC services paid as Medicare-certified ASC facilities, MDHHS will utilize a Medicare fee schedule with the MDHHS reduction factor applied.

a. Wrap Around Codes

MDHHS will cover the following codes differently (than Medicare) under its OPPS:

0479T	0480T	0482T	0487T	0491T	0492T	0493T
0502T	0503T	C9748	J1428	Q4176	Q4177	Q4178
Q4179	Q4180	Q4181	Q4182			

4. Oral/Maxillofacial Surgeons

15730	15733	31241	31253	31257	31259	31298
64912	64913	D9222	D9239			

5. Therapy Services

97763	G0515

6. Urgent Care Centers

71045	71046	71047	71048	74018	74019	74021
90756						

7. Dental Services

D5511	D5512	D5611	D5612	D5621	D5622	D9222
D9239						

8. Laboratory Services

81105*	81106*	81107*	81108*	81109*	81110*	81111*
81112*	81120*	81121*	81175*	81176*	81230*	81231*
81232*	81238*	81258*	81259*	81269*	81346*	81361*
81362*	81363*	81364*	81520*	81521*	86008	86794
87634	87662					

9. Medical Suppliers, Orthotists, and Prosthetists

E0953* E0954* Q0477

10. Cochlear Manufacturer

L8694*

11. Certified Nurse Midwife

J1726 J1729 J7296

12. Family Planning Clinic

J7296

13. Anesthesiologist Assistant & Certified Registered Nurse Anesthetist (CRNA)

00731 00732 00811 00812 00813

14. Federally Qualified Health Center and Tribal Health Center

71045	71046	71047	71048	74018	74019	74021
86008	90756	94617	94618	95249	97763	99483
D5511	D5512	D5611	D5612	D5621	D5622	G0516
G0517	G0518	J0565	J0606	J1555	J1627	J1726
J1729	J3358	J7210	J7211	J7296		

15. Rural Health Clinic

71045	71046	71047	71048	74018	74019	74021
86008	90756	94617	94618	95249	97763	99483
G0516	G0517	G0518	J0565	J0606	J1555	J1627
J1726	J1729	J3358	J7210	J7211	J7296	

16. Local Health Department and Child and Adolescent Health Center & Programs

71045	71046	71047	71048	74018	74019	74021
90756	94617	94618	95249	97763	J1726	J1729
J3358	J7210	J7211	J7296			

B. <u>NEW COVERAGE OF EXISTING CODES</u>

Effective for dates of service on and after January 1, 2018, existing HCPCS codes will be activated for coverage as identified in the following provider categories.

1. **Physicians, Practitioners, and Medical Clinics**

    90750 93668 R0070

2. **Urgent Care Centers**

    90750

3. **Local Health Department, Child and Adolescent Health Center & Programs, Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center**

    90750 R0070

4. **Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center**

    93668

5. **Telemedicine**

    90785 90839 90840 90966 96160 96161 99408
    99409

6. **OPPS Wrap Around Codes**

    90750

C. CHANGE IN COVERAGE OF EXISTING DENTAL CODE

Interim Caries Arresting Medicament Application (D1354) is billable once per date of service. A maximum of 5 teeth may be treated per visit. Effective January 1, 2018, providers are required to enter the tooth number(s)/letter(s) of all teeth treated in the comments section of the claim.

D. PRIOR AUTHORIZATION FOR EXISTING CODES

Effective for dates of service on and after September 1, 2017, the following HCPCS codes will require prior authorization:

V5030 V5040 V5120

Effective for dates of service on and after January 1, 2018, the following HCPCS codes will require prior authorization:

36475 36476 36478 36479 81222 81223 81228
81229 81242 81315 81316 81332 88235

E. RETROACTIVE COVERAGE OF EXISTING CODE FOR PHYSICIANS, PRACTITIONERS, MEDICAL CLINICS, CERTIFIED NURSE MIDWIFE

Effective for dates of service on and after July 1, 2017, MDHHS will cover the following HCPCS codes:

99408	99409

F. DISCONTINUE COVERAGE OF EXISTING CODES FOR ALL APPLICABLE PROVIDER TYPES

MDHHS will discontinue coverage of the following codes effective December 31, 2017:

37216	81220	81221	81224	90733	96567

G. DISCONTINUED 2018 HCPCS PROCEDURE CODES FOR ALL APPLICABLE PROVIDER TYPES

The following HCPCS codes are discontinued effective December 31, 2017:

00740	00810	01180	01190	01682	15732	29582	29583
31320	34800	34802	34803	34804	34805	34806	34825
34826	34900	36120	36515	55450	64565	69820	69840
71010	71015	71020	71021	71022	71023	71030	71034
71035	74000	74010	74020	75658	75952	75953	75954
77422	78190	83499	84061	86185	86243	86378	86729
86822	87277	87470	87477	87515	88154	93982	94620
97532	97762	99363	99364	0051T	0052T	0053T	0178T
0179T	0180T	0255T	0293T	0294T	0299T	0300T	0301T
0302T	0303T	0304T	0305T	0306T	0307T	0309T	0310T
0340T	0438T	A9599	C9140	C9483	C9484	C9485	C9486
C9487	C9489	C9490	C9491	C9494	D5510	D5610	D5620
G0202	G0204	G0206	G0364	G0502	G0503	G0504	G0505
G0507	G8696	G8697	G8698	G8879	G8947	G8971	G8972
G9381	G9496	J9300	Q9984	Q9985	Q9986	Q9987	Q9988
Q9989							

H. COVERAGE OF THE TRANSPORTATION AND SETUP OF PORTABLE X-RAY EQUIPMENT AND REQUIRED MODIFIERS

The transportation of portable x-ray equipment, set up and personnel is covered when furnished in a place or residence used as the patient's home as reported by HCPCS R0070 and R0075. These services must be provided under the order and general supervision of a physician. No transportation charge is payable unless the portable x-ray equipment was actually transported to the location where the x-ray was taken. For patients residing in a nursing facility, the transportation, set up and personnel costs are

included in the nursing facility's per diem rate and not separately reimbursable (refer to the Nursing Facility Chapter of the Medicaid Provider Manual for additional information).

Effective for dates of service on and after January, 2018, providers are required to report the appropriate Level II HCPCS modifier (UN, UP, UQ, UR, US) with HCPCS code R0075 relative to the number of patients served per trip to a location. Total payment for services will be adjusted by the number of patients served.

I. MODIFIER CLARIFICATION

Use of HCPCS Modifier - PN
Michigan Medicaid OPPS will implement the use of the CMS modifier PN, consistent with Medicare reporting requirements, effective January 1, 2017. Claim lines billed with the PN modifier will result in a reduction of 50% applied to the OPPS rate. Beginning with dates of service on or after January 1, 2018, claim lines billed with the PN modifier will be paid at 40% of the OPPS rate

Use of HCPCS Modifier – FX
Michigan Medicaid OPPS will implement the CMS payment reduction for x-ray services taken using film reported with modifier "FX". Note: When payment for an x-ray service taken using film is packaged into the payment for another item or service under the OPPS, no separate payment is made for the x-ray service taken using film.

Billing Instructions for OPPS 340B-Acquired Drugs
Effective January 1, 2018, separately payable Part B drugs (assigned status indicator "K"), other than vaccines (assigned status indicator "L" or "M") and drugs on pass-through payment status (assigned status indicator "G"), that are acquired through the 340B Program or through the 340B prime vendor program, will be paid according to Medicare guidelines when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. Hospital types that are excepted from the Medicare 340B payment policy in CY 2018 include rural Sole Community Hospitals (SCHs), children's hospitals, and Prospective Payment System (PPS) exempt cancer hospitals.

- Hospitals paid under the OPPS that are not excepted from the 340B drug payment policy for CY2018 are required to report modifier "JG" on the same claim line as the drug HCPCS code to identify a 340B-acquired drug.
- Excepted hospitals from the 340B adjustment, rural SCHs, children's hospitals and PPS-exempt cancer hospitals are required to report modifier "TB" for 340B-acquired drugs.
- Michigan Medicaid will continue to pay separately payable drugs not acquired under the 340B Program according to current payment methodology.
- All payments are subject to the Michigan Medicaid Reduction Factor.

Providers are also reminded that MSA 17-07 "Enhanced 340B Reporting Requirements" remains in effect and Institutional providers are to report Modifier U6 for all drugs purchased through the 340B program.

J. <u>CORRECTIONS TO PAST BULLETINS</u>

MSA 17-30

C9498 indicated it required Prior Authorization. The correct code is C9489, which requires Prior Authorization.

MSA 17-34

D1206 will be end dated on December 31, 2017 for medical providers.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kathy Stiffler, Acting Director
Medical Services Administration