Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2015-52**
www.ctdssmap.com **July 2015**

TO: Hospitals, Physicians, Physicians, Physician Assistants, Advanced Practice Registered Nurses, Certified Nurse Midwives, Optometrists, Optometrist Group, Podiatrist, and Podiatrist Group

RE: Billing Protocol for Services Provided in Emergency Rooms by Physicians Not Enrolled in Medicaid

---

The purpose of this provider bulletin is to reiterate to providers that PB 2004-76 "Billing Protocol for Services Provided in Emergency Rooms by Physicians Not Enrolled in Medicaid" is still in effect for claims today. Per the Connecticut Medical Assistance Program provider agreement hospitals are obligated to provide hospital services to Medicaid clients. These services include both the professional and technical components associated with the delivery of services in an emergency room.

Typically hospitals bill for professional services rendered by hospital staff in the emergency room using Revenue Center Code (RCC) 981 (Professional Fee/ Emergency Room). If a hospital chooses to enter into a separate arrangement with a physician or physician group to provide the professional component of emergency room services, the hospital should either ensure that the provider is enrolled in Medicaid or bill for the professional component using RCC 981. If the hospital bills using RCC 981, it should make payment arrangements directly with the physician or physician group. The hospital is still ultimately responsible for the provision of services and under **no circumstances** should a physician or physician group bill the client directly for those services.

As a reminder and as previously communicated in PB 2013-24, Sections 6401 and 6501 of the Affordable Care Act (ACA) requires that ordering, prescribing, and referring providers who render services to HUSKY clients be enrolled in the Connecticut Medical Assistance Program (CMAP). To support this mandate, the Department of Social Services (DSS) implemented claim edits to validate that attending, referring, ordering and rendering providers submitted on Institutional, Professional and Dental claims are enrolled in the CMAP. If a non-enrolled Medicaid provider renders services to a Medicaid client in the emergency room, the claim may deny. Please refer to PB 2013-56, 2013-59, and 2013-60 for a list of claim edits depending on your provider type.

DSS strongly recommends that providers encourage their attending, referring, ordering and rendering providers to enroll in the CMAP in order to avoid future claim denials.

If you have any questions regarding this provider bulletin, 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.