DEPARTMENT OF SOCIAL SERVICES

Corrected and Updated: Notice of Proposed Medicaid State Plan Amendment (SPA)

HIPAA Billing Code and Reimbursement Update – Medical Equipment, Devices and Supplies (MEDS) Reimbursement Update (SPA 17-M)

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Correction and Update to Initial Notice

On February 28, 2017, a public notice for this SPA was published in the Connecticut Law Journal. This notice makes one correction and one update to that notice (which were also noted on the document posted with the SPA page on the DSS website as of February 28, 2017), as follows:

Correction: A typographical error was later identified in the fiscal information section. That notice incorrectly noted an increase in costs, even though the SPA will instead reduce annual aggregate expenditures, as was made clear by the individual descriptions of each of the changes and in the inclusion of the paragraph regarding compliance with federal access regulations. That error is corrected in this corrected and updated notice.

Update: In addition, procedure code A7048 was inadvertently omitted from the description in the body of the notice. However, it has been added to this updated notice.

Changes to Medicaid State Plan

Effective on or after March 1, 2017, SPA 17-M will amend Attachment 4.19-B of the Medicaid State Plan as described below:

1. This SPA will incorporate several of the 2017 Healthcare Common Procedure Coding System (HCPCS) (additions, deletions and description changes) to the Medical Equipment, Devices and Supplies (MEDS) fee schedules. DSS is making these changes to ensure that these fee schedules remain compliant with the Health Insurance Portability and Accountability Act (HIPAA). The new codes are being priced as follows: A4224: $19.24; A4225: $2.60; L8690: $4495.14; and L3891: Actual Acquisition Cost plus 40%.

2. This SPA will change the quantities allowed per month without prior authorization for the following procedure codes: A4400, A4630, A7000, A7002, A7006, A7015, A7016, A9276 and K0552. Additional units that are medically necessary may be reimbursed with prior authorization (PA).

3. This SPA discontinues certain procedure codes from the orthotics and prosthetics fee schedule to account for the lack of utilization and/or to ensure only braces that are medically

necessary are provided to members. The following procedure codes are being discontinued effective March 1, 2017:

L0455	L0457	L0458	L0462	L0464
L0467	L0469	L0474	L0648	L0650
L0651	L1833	L1848	L3674	L3730
L3740	L3900	L3901	L3904	L3916

In addition, this SPA will discontinue the repair option to the transcutaneous electrical nerve stimulators and the osteogenesis electrical stimulators under procedure codes: E0720, E0730, E0731, E0747, E0748 and E0760.

4. This SPA increases the fees to the following procedure codes in order to more actually reflect the cost of these items:

Procedure Code	Current Fee	Revised Fee
A7520	$40.36	$52.86
A7521	$39.99	$52.36
A7522	$38.39	$50.28
V5260	$950.00	$1000.00
V5261	$950.00	$1000.00

In addition, procedure code A7048 will be manually priced at actual acquisition cost plus 25% effective March 1, 2017.

5. This SPA revises the rental reimbursement fees for certain procedure codes in order to not exceed the purchase price of the item, if the item was continually rented for 10 months. The rental fees for the following procedure codes are being lowered in this manner:

E0100	E0105	E0110	E0111	E0112
E0113	E0114	E0116	E0130	E0135
E0141	E0143	E0153	E0154	E0155
E0156	E0158	E0160	E0161	E0163
E0188	E0199	E0200	E0249	E0424
E0439	E0560	E0561	E0562	

6. This SPA lowers the repair fees to $100 for certain procedure codes in order to ensure appropriate pricing. However, any repairs which cost over $100 may be authorized with prior authorization when medically necessary. Below is a list of the affected procedure codes:

L0112	L0113	L0180	L0190	L0200

L0452	L0454	L0456	L0460	L0466
L0468	L0470	L0472	L0480 through L0492	L0622
L0627	L0631 through L0640	L0642	L0649	L0700 through L0710
L0810 through L0859	L1000 through L1005	L1200	L1230	L1300
L1310	L1652	L1680 through L1755	L1831	L1832
L1834	L1840 through L1847	L1850 through L1860	L1900	L1904
L1907	L1920 through L2034	L2036 through L2038	L2050	L2060
L2080 through L2136	L2188	L2192	L2250	L2280
L2330	L2340	L2350	L2510	L2525
L2540	L2627 through L2640	L3671	L3702	L3720
L3760	L3763 through L3806	L3808	L3809	L3905
L3906	L3913	L3915	L3919	L3921
L3960 through L3978	L3981 through L3984	L4000	L4631	

7. This SPA decreases reimbursement amounts to certain procedure codes. These reimbursement changes are based on pricing in other states' Medicaid Program and pricing research conducted by the Department.

   Procedure code A6549, which is a manually priced procedure code, will be reduced from actual acquisition cost (AAC) plus 45% to AAC plus 25%.

   Procedure code S1040 was also reduced in order to be consistent with fees paid by other states and to contain costs.

In addition, the fees for several orthoses which are custom fabricated or customized to fit a specific member by an individual with expertise will be reduced by 10% and are marked with an asterisk* below.

Finally, any off-the-shelf parallel codes to the custom-fitted versions of the same item were lowered to the same reimbursement fee as the custom-fitted procedure codes. This change improves pricing consistency.

The following is a list of all the procedure codes with the reimbursement reduction described above:

A4630	A4670	A7005	E0305	E0310
E0445	E0570	E0720	E0730	E0731
E0747	E0748	E0760	L0627*	L0631*
L0635*	L0636*	L0637*	L0638*	L0639*
L0640*	L0641	L0642	L0643	L0649
L1812	L1831*	L1832*	L1834*	L1840*
L1843*	L1844*	L1845*	L1846*	L1847*
L1850	L1860*	L3760*	L3807*	L3809
L3915*	L3918	L3924	L3930	L4360
L4361	L4370	L4386*	L4387	L4397

Fee schedules are published at this link: http://www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download."

Fiscal Information

DSS estimates that this SPA will decrease annual aggregate expenditures by approximately 424,000 in State Fiscal Year (SFY) 2017 and approximately $1.7 million in SFY 2018.

Compliance with Federal Access Regulations

In accordance with federal regulations at 42 C.F.R. §§ 447.203 and 447.204, DSS is required to ensure that there is sufficient access to Medicaid services, including services where payment rates are proposed to be reduced. Those federal regulations also require DSS to have ongoing mechanisms for Medicaid members, providers, other stakeholders, and the public to provide DSS with feedback about access. In addition to other available procedures, anyone may send DSS comments about the potential impact of this SPA on access to medical equipment devices and

supplies for which rates are being reduced or payment is being restructured in a manner that could affect access, as part of the public comment process for this SPA. Contact information and the deadline for submitting public comments are listed below.

Information on Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: http://www.ct.gov/dss. Go to "Publications" and then "Updates". The proposed SPA may also be obtained at any DSS field office or the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: ginny.mahoney@ct.gov or write to: Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5145, Fax: 860-424-5799). Please reference "SPA 17-M: Medical Equipment, Devices and Supplies (MEDS) Reimbursement Update".

Anyone may send DSS written comments about this SPA, including comments about access to the services for which this SPA proposes to reduce rates or restructure payments in a manner that could affect access. Written comments must be received by DSS at the above contact information no later than March 30, 2017.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

Home Health Services –

(a) Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area are provided with limitations.
(b) Home health aide services provided by a home health agency with limitations.
(d) Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility are provided with limitations.

The fee schedule for licensed home health care agencies for service (a), (b), and (d) above can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." Home health service rates were set as of July 1, 2016 and are effective for services on or after that date. Rates are the same for private and governmental providers and are published on the agency's website. Any fee payable to a home health care agency may qualify for an add-on to the standard fee for the applicable home health service upon application by the agency evidencing extraordinary costs associated with (1) treating AIDS patients; (2) high risk maternal child health care; (3) escort security services or (4) extended hour services. The provider must complete the appropriate application form showing the incremental costs that the agency incurs for the service. The allowable added cost is divided by all projected visits with and without the additional special circumstance (i.e., 1, 2, 3 or 4 above). The Department may add or delete codes in order to remain compliant with HIPAA. In no case will the fee paid to an agency exceed the agency charge to the general public for similar services.

(c) Medical supplies, equipment and appliances suitable for use in the home – The current fee schedule was set as of March 1, 2017 and is effective for services provided on or after that date, except that codes may be deleted or added in order to remain compliant with HIPAA. The fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." Over-the-counter products provided by pharmacies are reimbursed at Average Wholesale Price (AWP). All governmental and private providers are reimbursed according to the same fee schedule.

Private duty nursing services – Not provided.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE CONNECTICUT

(b) Prosthetic devices

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of prosthetic devices. The agency's rates were set as of March 1, 2017 and are effective for services rendered on or after that date. The fee schedule is subject to periodic adjustment. All rates are published on the agency's website at www.ctdssmap.com. Select "Provider," then select "Provider Fee Schedule Download."

(c) Eyeglasses

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of eyeglasses. The agency's rates were set as of 7/1/2008 and are effective for services rendered on or after that date. The fee schedule is subject to periodic adjustment. All rates are published on the agency's website at www.ctdssmap.com. Select "Provider," then select "Provider Fee Schedule Download."

(d) Hearing aids

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of prosthetic devices. The agency's rates were set as of March 1, 2017 and are effective for services rendered on or after that date. The price allowed shall be the actual acquisition cost of the hearing aid(s) to the provider, not to exceed the applicable rates on the Hearing Aid/Prosthetic Eye fee schedule, which are published on the agency's website at www.ctdssmap.com. Select "Provider," then select "Provider Fee Schedule Download."