DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 19-K: Medical Equipment Devices and Supplies (MEDS) Fee Schedule Update and Special Services - Birth to Three Years Fee Schedule Update

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).

Changes to Medicaid State Plan

Effective on or after March 1, 2019, SPA 19-K will amend Attachment 4.19-B of the Medicaid State Plan in order to make the changes described below. This SPA will incorporate the 2019 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) to the MEDS Fee Schedule and to the Special Services - Birth to Three Years fee schedule. These revisions are necessary to ensure that the fee schedules remain compliant with the Health Insurance Portability and Accountability Act (HIPAA). In addition, the MEDS fee schedule also includes several pricing changes to several procedure codes, as described below. These changes apply to all MEDS reimbursed under the HUSKY Health programs (HUSKY A, B, C and D).

Special Services - Birth to Three Years

This SPA does not make any additional changes to reimbursement for Birth to Three services other than the HIPAA compliance update described above.

MEDS

The Department has added the following codes to the medical surgical supply fee schedule and the orthotic and prosthetic fee schedule:

Procedure Code	Procedure Code Description	Fee
A5514	Mult density insert dir carv/cam	$40.10
A9286	Hygienic item or device, any type	Manually priced
L8701	Power upper extremity…rom device…custom fabricated	Manually priced

L8702	Power upper extremity…rom device…finger..custom fabricated	Manually priced
L5859	Knee-shin pro flex/ext cont	$11,271
L6715	Term device, multi art digit	$2,452
L6880	Elec hand ind art digits	$18,559

The Department has discontinued several contralateral hearing aid codes and added the replacements codes that more accurately describe current hearing aid technology used to treat patients with single sided deafness or patients with some degree of hearing loss in one ear and an unaidable hearing loss in the other which reflects coding set revisions by the Centers for Medicare & Medicaid Services (CMS). Below is a list of the discontinued (D) codes and the replacement contralateral hearing aid codes which are being added (A):

Code	**Modifier**	**Description**	**D = Discontinued A = Added**	**Fee**
V5170	RB	Within ear cros hearing aid	D	Cost + 75
V5170		Within ear cros hearing aid	D	$ 410
V5171		Hearing aid monaural ite	A	$ 410
V5172		Hearing aid monaural itc	A	$ 410
V5180		Behind ear cros hearing aid	D	$ 410
V5180	RB	Behind ear cros hearing aid	D	Cost + 75
V5181		Hearing aid monaural bte	A	$ 410
V5210	RB	In ear bicros hearing aid	D	Cost + 75
V5210		In ear bicros hearing aid	D	$ 516
V5211		Hearing aid binaural ite/ite	A	$ 516
V5212		Hearing aid binaural ite/itc	A	$ 516
V5213		Hearing aid binaural ite/bte	A	$ 516
V5214		Hearing aid binaural itc/itc	A	$ 516
V5215		Hearing aid binaural itc/bte	A	$ 516
V5220		Behind ear bicros hearing aid	D	$ 516
V5220	RB	Behind ear bicros hearing aid	D	Cost + 75
V5221		Hearing aid binaural bte/bte	A	$ 516

These revisions to the contralateral hearing aids codes are anticipated to be cost neutral, as the Department priced the replacement codes at the same fee that was previously established for these contralateral hearing aid codes. Providers are allowed to submit prior authorization requests if the actual acquisition cost for the CROS hearing aid is greater than these previously established fees. In addition, repairs performed by the manufacturer's or third party vendor's continue to be limited to the manufacturer or third party vendor actual costs plus $75.

Effective on or after March 1, 2019, the Department has established fees for the following prosthetic procedure codes that used to be manually priced:

Code	Description	Fee
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system…includes any type motors(s)	$11,271
L6715	Terminal device, multiple articulating digit…initial issue or replacement	$ 2,452
L6880	Electric hand, switch or myoelectric controlled, independently articulating digits…includes motor(s)	$18,559

Manually Priced Items

Complex rehab technology (CRT) items are paid at list price minus 18% as specified on the DSS Pricing Policy for MEDS Items. For procedure codes that are manually priced, providers refer to the DSS Pricing Policy for MEDS Items which is posted on the HUSKY Health Web Site at www.ct.gov/husky. To access the link, click on "For Providers" followed by "Policies, Procedures and Guidelines" under the "Medical Management" menu item. Scroll down to the "Clinical Policies" and click on the "DSS Pricing Policy for MEDS Items".

Several procedure codes which have the "Lst-15" fee listed under the repair modifier segment will be revised as the repairs require prior authorization and these codes are manually priced: E1009, E1011, E2295; E2512; E2599; E2609, E2617, E8000, E8001, E8002, K0669 and K0900.

Effective on or after March 1, 2019, the Department is creating a new modifier, "UC – Upon Strict Review of the Department" which will be used when reviewing medically necessary pediatric wheelchair trays requiring special consideration and will be covered pursuant to Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) for HUSKY children under age 21. These specialty pediatric wheelchair trays will require prior authorization and will be reviewed for medical necessity and will be priced as determined by the Department. Please refer to the "DSS Pricing Policy for MEDS Items" for information on the UC modifier.

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

Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures by approximately $9,600 in State Fiscal Year (SFY) 2019 and $40,000 in SFY 2020.

Obtaining SPA Language and Submitting Comments

This SPA is posted on the DSS web site at the following link: http://portal.ct.gov/dss. Scroll down to the bottom of the webpage and click on "Publications" and then click on "Updates." Then click on "Medicaid State Plan Amendments". The proposed SPA may also be obtained at any DSS field office, at 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: Public.Comment.DSS@ct.gov or write to: Medical Policy Unit, Department of Social Services, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference "SPA 19-K: MEDS Fee Schedule Update and Special Services - Birth to Three Years Fee Schedule 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 13, 2019.

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(7) 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.

(c) 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 (c) 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 January 1, 2019 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. 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.

(d) Medical supplies, equipment and appliances suitable for use in the home – The current fee schedule was set as of March 1, 2019 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.

(8) Private duty nursing services – Not provided.

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(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, 2019 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, 2019 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."

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b.2. Early Intervention Services (EIS) Pursuant to EPSDT. The current fee schedule was updated as of March 1, 2019 and is effective for services provided on or after that date. The fee schedule is posted to the Connecticut Medical Assistance Program website at this link: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." All governmental and private providers are reimbursed according to the same fee schedule.