Connecticut Medical Assistance Program Provider Bulletin 2017-05
Policy Transmittal 2017-04 February 2017

Effective Date: March 1, 2017
Roderick L. Bremby, Commissioner Contact: Ginny Mahoney@ 860-424-5145

TO: Medical Equipment Devices and Supplies (MEDS) Providers

RE: Updated MEDS Fee Schedule Changes

1. HIPAA Compliance Update

Effective March 1, 2017, the Department of Social Services is revising its fee schedule, which includes the addition, deletion and description changes for codes on the MEDS fee schedule consistent with Healthcare Common Procedure Coding System (HCPCS) updates. These revisions are necessary to ensure that the MEDS fee schedule remains compliant with the Health Insurance Portability and Accountability Act (HIPAA). These changes apply to all MEDS reimbursed under the HUSKY Health program, which includes HUSKY A, HUSKY B, HUSKY C and HUSKY D.

2. Quantity Changes

Effective March 1, 2017, the Department will change the quantities allowed **per month** 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). However, PA **will not** override the daily federally required National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUE).

3. Prior Authorization Changes

Effective March 1, 2017, the following procedure codes for hospital beds will require PA: E0250, E0251, E0255, E0256, E0290 through E0297.

Procedure code E2619 will no longer require PA.

4. Discontinued Procedure Codes

The Department will discontinue 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. Providers are reminded that a custom-fitted brace requires the expertise of a certified orthotist or an individual who has equivalent specialized training (such as a physician, physician assistant, advanced practice registered nurse, occupational therapist or physical therapist) in the provision of orthosis to ensure proper fitting of the item. 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, the Department will discontinue the repair option to the transcutaneous electrical nerve stimulators and the osteogenesis electrical stimulators: E0720, E0730, E0731, E0747, E0748 and E0760.

5. Reimbursement Fee Increases for Certain Procedure Codes

The Department will increase the fees to the following procedure codes in order to more accurately 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

6. Reimbursement Decreases to Codes on the MEDS Fee Schedule

Effective March 1, 2017, the Department will lower fees to certain procedure codes found on the MEDS fee schedule. 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%.

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 reductions 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
S1040				

7. <u>Reduction to Repair Fees for Certain Codes on the Orthotic and Prosthetic Fee Schedule</u>

The Department will lower 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 PA 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	

8. <u>Reduction in Rental Fees</u>

The Department will lower the rental fees for the following procedure codes in order to not exceed the purchase price of the item if continually rented for 10 months. Rental payment amounts shall not exceed the purchase price of the item:

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	

Compliance with Federal Access Regulations

In accordance with federal regulations at 42 C.F.R. §§ 447.203 and 447.204, the Department 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 the Department to have ongoing mechanisms for Medicaid members, providers, other stakeholders, and the public to provide the Department with feedback about access. In addition to other available procedures, providers (as well as Medicaid members and other stakeholders) may give the Department feedback about the impact of the changes described above that reduce reimbursement rates for specified MEDS billing codes. Written feedback about access may be sent to the Department's contact listed at the bottom of this policy transmittal.

Accessing the Fee Schedules: The updated MEDS fee schedule is available on the Connecticut Medical Assistance Program Web site at www.ctdssmap.com.

From this Web page, go to "Provider", then to "Provider Fee Schedule Download". Click on the "I Accept" button and scroll down to "MEDS – Durable Medical Equipment" fee schedule, the "MEDS - Medical/Surgical Supplies" fee schedule, the "MEDS - Prosthetic/Orthotic" fee schedule, the "MEDS - Hearing Aid/Prosthetic Eye" fee schedule, the "MEDS – Miscellaneous" fee schedule, or the "MEDS - Parenteral/Enteral" fee schedule. Press and hold the CTRL key, then click on the CSV link. Continue to hold the CTRL key until a dialogue box appears with the option to open or save the fee schedule.

Posting Instructions: MEDS providers should replace their existing MEDS fee schedule with the new one. Policy transmittals can be downloaded from the Connecticut Medical Assistance Program Web site at www.ctdssmap.com.

Distribution: This policy transmittal is being distributed to providers of the Connecticut Medical Assistance Program by Hewlett Packard Enterprise.

Responsible Unit: DSS, Division of Health Services, Medical Policy and Regulations, Ginny Mahoney, Policy Consultant (860) 424-5145.

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