Connecticut interChange MMIS

Provider Manual

Chapter 7 - Medical Services (MEDS)

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Connecticut Department of Social Services (DSS)
55 Farmington Avenue
Hartford, CT 06105

Gainwell Technologies
55 Hartland Street
East Hartford, CT 06108

CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Medical Equipment, Devices, and Supplies Regulation/Policy
Chapter 7

This section of the Provider Manual contains the Medical Services Policy and Regulations of Connecticut State Agencies pertaining to medical equipment, devices, and supplies.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Medical Equipment, Devices, and Supplies

Requirements for Payment of Medical Equipment, Devices, and Supplies

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Requirements for Payment of Medical and Surgical Supplies

Section 17b-262-712. Scope

Sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment to providers of medical and surgical supplies provided to eligible Medicaid clients residing at home.

Sec. 17b-262-713. Definitions

As used in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Commissioner" means the Commissioner of Social Services or his or her designee;

(4) "Department" means the Department of Social Services or its agent;

(5) "Documented in writing" means handwritten, typed or computer printed;

(6) "EPSDT (Early & Periodic Screening & Diagnostic Treatment) special services" means services provided in accordance with subdivision 1905 (r) of the Social Security Act;

(7) "Home" means the client's place of residence, including a boarding home, community living arrangement or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(8) "Hospital" means "short-term hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(9) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(10) "Licensed practitioner" means an individual who is licensed by the Connecticut Department of Public Health, another state, District of Columbia or the Commonwealth of Puerto Rico and is acting within his or her scope of practice under Connecticut state law in prescribing a medical or surgical supply;

(11) "Medical and surgical supplies" or "supply" means treatment products that:

(A) are fabricated primarily and customarily to fulfill a medical or surgical purpose;

(B) are used in the treatment or diagnosis of specific medical conditions;

(C) are generally not useful in the absence of illness or injury; and

(D) are generally not reusable and are disposable.

(12) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(13) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(14) "Medical necessity" or "medically necessary" means health care needed to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;

(16) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed and dated by the licensed practitioner issuing the order;

(17) "Prior authorization" or "PA" means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(18) "Provider" means a vendor or supplier of medical and surgical supplies who is enrolled with the department as a supplier of medical and surgical supplies;

(19) "Provider agreement" means the signed, written contractual agreement between the department and the provider; and

(20) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-714. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

Sec. 17b-262-715. Eligibility

Payment for medical and surgical supplies is available for clients who have a medical necessity for such supplies, when the supplies are prescribed by a licensed practitioner, subject to the conditions and limitations set forth in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies.

Sec. 17b-262-716. Supplies covered and limitations

(a) Supplies covered

(1) The department shall pay for the purchase of medical and surgical supplies, except as limited by sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies, that conform to accepted methods of diagnosis and treatment and are medically necessary and medically appropriate.

(2) Payment for medical and surgical supplies is available only to clients who live at home.

(3) The department shall maintain a non-exclusive fee schedule of supplies which it has determined meet the department's definition of medical and surgical supplies and for which coverage shall be provided to eligible clients, subject to the conditions and limitations set forth in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies.

(4) When the supply for which coverage is requested is not on the department's fee schedule, prior authorization is required for that supply. The provider requesting coverage for a prescribed supply not on the list shall submit a prior authorization request to the department through an

enrolled provider of medical and surgical supplies. Such request shall include a prescription and documentation showing the client's medical necessity for the prescribed supply. The provider also shall include documentation showing that the supply meets the department's definition of a medical and surgical supply and is medically appropriate for the client requesting coverage of such supply.

(5) The department shall pay for medical and surgical supplies for EPSDT special services.

(b) Limitations

(1) The department shall not pay for anything of an unproven, experimental or research nature or for supplies in excess of those deemed medically necessary by the department to treat the client's condition or for supplies not directly related to the client's diagnosis, symptoms or medical history.

(2) A prescription shall be valid for no longer than one year.

(3) The department may set maximum allowable quantity limitations at levels that it determines to be reasonable.

(4) Automatic shipment of goods and products shall not be allowed. Any refills shall be made only at the request of the client or the client's authorized representative with a valid prescription.

Sec. 17b-262-717. Supplies not covered

The department shall not pay providers for:

(1) standard or stock medical and surgical supplies prescribed and ordered for a client who:

(A) dies prior to delivery of the supply; or

(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the supply is delivered;

(2) medical and surgical supplies provided to clients in hospitals, chronic disease hospitals, nursing facilities or ICF/MRs;

(3) drugs and supplements, including, but not limited to, over-the-counter supplies such as cough medicines, herbal remedies and laxatives; and

(4) any supply routinely used for personal hygiene.

Sec. 17b-262-718. Prior authorization

(a) To receive payment from the department, providers shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements are met.

(b) The department requires prior authorization for any supply identified on the department's published fee schedule as requiring prior authorization or any supply not on the department's fee schedule.

(c) A prior authorization request, on forms and in a manner as specified by the department, shall include documentation of medical necessity and shall be signed by the prescribing licensed practitioner and the supplier. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

Sec. 17b-262-719. Billing procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically transmitted to the department or its agent, in a form and manner that the department shall specify and shall include all information that the department shall require to process the claim for payment.

(b) Claims submitted for medical and surgical supplies not requiring prior authorization shall include the name of the licensed practitioner prescribing the supplies. A licensed practitioner's original prescription for the supplies shall be on file in the client's record with the provider and shall be subject to review by the department.

(c) Providers shall use the Healthcare Common Procedure Coding System (HCPCS), as maintained and distributed by the United States Department of Health and Human Services, for billing for medical and surgical supplies. Providers shall consult the Medicare SADMERC (Statistical Analysis Durable Medical Equipment Regional Carrier) if necessary to determine the proper billing code. A miscellaneous HCPCS code shall not be used unless a specific HCPCS code is not available for a supply. If a provider submits a prior authorization request to the department using a miscellaneous code for a supply that has a specific HCPCS code, the authorization request shall be denied.

(d) Providers shall bill the usual and customary charge.

(e) The department shall pay the lowest of:

(1) the lowest Medicare rate;

(2) the amount in the applicable fee schedule as published by the department;

(3) the provider's usual and customary charge; or

(4) the amount previously authorized in writing by the department.

Sec. 17b-262-720. Payment limitations

The price for any supply listed in the fee schedule published by the department shall include and the department shall pay the lowest:

(1) fees for initial measurements, fittings and adjustments and related transportation costs;

(2) labor charges;

(3) delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional charges to be made for packing or shipping;

(4) travel to the client's home;

(5) technical assistance to the client to teach the client, or his or her family, the proper use and care of the supplies;

(6) information furnished by the provider to the client over the telephone; and

(7) the provider shall accept the department's payment as payment in full.

Sec. 17b-262-721. Documentation

(a) All required documentation shall be maintained for at least five years or the length of time required by statute in the provider's file subject to review by the department. In the event of a dispute concerning a service or a supply provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute, whichever is longest.

(b) Failure to maintain all required documentation shall result in the disallowance of payment and recovery by the department of any amounts paid to the provider for supplies for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for medical and surgical supplies shall be on file with the provider and shall be subject to review by the department.

(d) The department requires that providers maintain fiscal and medical records to fully disclose services and goods rendered or delivered to clients.

(e) A signed receipt is required for all deliveries of medical and surgical supplies documenting that the client or, if the client is unable to sign, a designated representative or adult other than the provider or the provider's employee, took delivery of the supply. The receipt for medical and surgical supplies, regardless of format used, shall, at a minimum, contain the following elements:

(1) provider's name;

(2) client's name;

(3) delivery address;

(4) date of delivery; and

(5) itemization of the medical and surgical supplies delivered, including:

(A) product description;

(B) brand name;

(C) quantity delivered; and

(D) amount billed per supply.

(f) All orders for medical and surgical supplies, regardless of format used, which includes verbal, telephone and faxed orders, shall, at a minimum, contain the following:

(1) client's name, address and date of birth;

(2) diagnosis for which the medical and surgical supplies are required;

(3) detailed description of the medical and surgical supplies, including quantities and directions for usage, when appropriate;

(4) length of need for the medical and surgical supplies prescribed;

(5) name and address of prescribing practitioner; and

(6) prescribing practitioner's signature and date signed.

(g) Original prescriptions for medical and surgical supplies shall be obtained from the prescribing practitioner prior to submitting claims for payment.

(h) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deem necessary to assure compliance with these and other regulatory and statutory requirements.

Sec. 17b-262-722. Other

(a) Where brand names or stock numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(b) The provider shall instruct the client or his or her family, designated representative or adult, on the proper use and care of the supply. This instruction shall be provided as a part of the cost of the supply.

(c) Providers shall notify the department of returns of medical and surgical supplies delivered to a client. Providers shall initiate necessary reimbursement adjustments resulting from such returns.

(d) The provider shall maintain a current usual and customary price list.

Requirements for Payment for Hearing Aids and Supplies

Section 17b-262-792. Scope

Sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to providers of hearing aids and supplies that are medically necessary and that are provided to clients who are determined to be eligible to receive such goods and services under Medicaid pursuant to section 17b-262 of the Connecticut General Statutes.

Sec. 17b-262-793. Definitions

As used in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Actual acquisition cost" means the price paid to a manufacturer by a hearing aid provider for a hearing aid or accessory, as documented on the manufacturer's invoice, less any applicable discounts or rebates. The actual acquisition cost shall be verified by a copy of the manufacturer's invoice;

(2) "Advanced practice registered nurse" means a person who is licensed pursuant to section 20-94a of the Connecticut General Statutes;

(3) "Audiologist" means a person who is licensed under Chapter 399 of Connecticut General Statutes as an audiologist;

(4) "Audiometric report" means a written report that describes the results of measurement of overall performance in hearing, understanding and responding to speech for a general assessment of hearing and an estimate of the degree of practical handicap. The results are recorded on a graph or grid, also called an audiogram, to show the results and the impact of the hearing loss;

(5) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1(b)(2) of the Regulations of Connecticut State Agencies;

(6) "Client" means a person eligible for goods or services under the Medicaid program;

(7) "Commissioner" means the Commissioner of Social Services or his or her designee;

(8) "Department" means the Department of Social Services or its agent;

(9) “Dispensing fee” means a one-time fee pertaining to the selection, orientation, training in proper use, fittings and adjustments required within the first year of service;

(10) “Documented in writing” means handwritten, typed or computer printed;

(11) “Early Periodic Screening, Diagnosis and Treatment special services" or “EPSDT special services” means services that are not otherwise covered under Connecticut’s Medicaid program but which are nevertheless covered as EPSDT services for Medicaid-eligible children pursuant to the requirements of 42 U.S.C. 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider, and the service is a type of service that may be covered by a state Medicaid agency and qualify for federal reimbursement under 42 U.S.C. 1396b and 42 U.S.C. 1396d;

(12) “Ear specialist” means any licensed physician who specializes in diseases of the ear and is medically trained to identify the symptoms of deafness in the context of the total health of the patient, and is qualified by special training to diagnose and treat hearing loss. Such physicians are also known as otolaryngologists, otologists and otorhinolaryngologists;

(13) “Hearing aid” means any wearable instrument designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments or accessories, excluding batteries and ear molds;

(14) “Hearing aid dealer” means a “licensed hearing instrument specialist” as defined in section 20-396 of the Connecticut General Statutes or a “hearing aid dealer” as described in section 20-406-1 to 20-406-15, inclusive, of the Regulations of Connecticut State Agencies;

(15) “Hearing aid supplies” means those items purchased by the provider that are necessary for the proper operation of the hearing aid;

(16) “Hearing testing” means the measurement of an individual’s level of hearing, as set forth in section 20-406-9(f) of the Regulations of Connecticut State Agencies, for the purpose of determining if a hearing aid is medically necessary;

(17) “Home” means the client’s place of residence including, but not limited to, a boarding home, community living arrangement or residential care home. “Home” does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(18) “Hospital” means a “short-term hospital” as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(19) “Intermediate care facility for the mentally retarded” or “ICF/MR” means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(20) “Licensed practitioner” means a physician, a physician assistant or an advanced practice registered nurse;

(21) “Medicaid” means the program operated by the department pursuant to section 17b-261 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(22) “Medical evaluation” means an examination to ensure that all medically treatable conditions that may affect hearing are identified and treated first and the client is an appropriate candidate for a hearing aid;

(23) “Medical necessity” or “medically necessary” has the same meaning as in section 17b-259b of the Connecticut General Statutes;

(24) “Nursing facility” means “nursing facility” as defined in 42 USC 1396r(a), as amended from time to time and licensed according to section 19-13-D8t(b) of the Regulations of Connecticut State Agencies as a chronic and convalescent home or rest home with nursing supervision;

(25) “Physician” means a person licensed pursuant to section 20-10 of the Connecticut General Statutes;

(26) “Physician assistant” means “physician assistant” as defined in section 20-12a(5) of the Connecticut General Statutes;

(27) “Practice of fitting hearing aids” means “practice of fitting hearing aids” as defined in section 20-396 of the Connecticut General Statutes;

(28) “Prescription” means an original, written order documenting medical necessity that is signed and dated by the licensed practitioner who issued the order;

(29) “Prior authorization” or “PA” means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(30) “Provider” means the vendor or supplier of a hearing aid and supplies who is enrolled with the department as a hearing aid dealer;

(31) "Replacement of a hearing aid" means any occasion in which a new hearing aid is to take the place of a prior hearing aid; and

(32) "Usual and customary charge" means the amount that the provider accepts for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is accepted in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-794. Provider participation

To enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies and sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies.

Sec. 17b-262-795. Need for service

(a) The department shall pay for the purchase or repair of a medically necessary hearing aid or supply, subject to the conditions and limitations described in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

(b) All clients who have been identified as having a hearing loss, such as through the performance of a hearing screening, shall receive a medical evaluation by a licensed practitioner, preferably an ear specialist, before a hearing aid is considered to ensure that all medically treatable conditions that affect hearing are identified and treated first. The medical evaluation shall have taken place within the six-month period prior to the date in which the client receives the first hearing aid and may, at the licensed practitioner's discretion, be accompanied by a prescription for a hearing aid.

(c) Medical necessity shall be documented by the provider and shall include:

(1) An estimate of the client's ability to benefit from the use of a hearing aid as demonstrated by improvement in speech discrimination or environmental awareness of sound;

(2) test results showing the client's current hearing level and an estimate of improvement in speech discrimination or environmental awareness of sound;

(3) evidence of a medical evaluation signed by a licensed practitioner; and

(4) a written prescription signed by a licensed practitioner or an order by an audiologist or hearing aid dealer.

(d) In addition the provider shall document:

(1) The commitment on the part of the appropriate caregiver to assist the client in the use and care of the hearing aid, if the client is incapable of caring for the hearing aid on his or her own; and

(2) the status of any previous hearing aid used by the client.

(e) The department shall pay for hearing aids and supplies for a client who lives at home or in a nursing facility, ICF/MR, hospital or chronic disease hospital, except as limited by sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

(f) All hearing aids dispensed to a child under eighteen years of age shall meet the requirements of section 20-406-10 of the Regulations of Connecticut State Agencies.

(g) Hearing testing shall meet the requirements of section 20-406-9(f) of the Regulations of Connecticut State Agencies.

(h) There shall be a thirty-day trial period for a hearing aid in accordance with section 20-402a of the Connecticut General Statutes; the cancellation fee applies to the total acquisition cost and dispensing fee.

(i) An audiometric report to support medical necessity is required for the purchase of all hearing aids.

(j) A hearing aid shall be replaced only when the prior hearing aid no longer meets the client's needs, has been lost, stolen or damaged beyond repair.

(k) For a hearing aid that has been lost, stolen or damaged beyond repair, the provider shall document:

(1) The disposition of the prior hearing aid and statement of circumstances of loss or damage;

(2) in the case of damage, a statement from the hearing aid dealer or audiologist that the hearing aid cannot be repaired;

(3) the measures to be taken by the client, family or other caregiver, to prevent future loss or damage.

(l) For a hearing aid that is no longer meets the client's needs, the provider shall document the significant change in the client's hearing loss to warrant the replacement.

Sec. 17b-262-796. Eligibility

Payment to a provider for hearing aids and related supplies is available for clients who have a need for such products and services which meets the department's definition of a hearing aid when the items are medically necessary, subject to the conditions and limitations set forth in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

Sec. 17b-262-797. Services covered and limitations

(a) The department shall maintain a fee schedule for hearing aids and supplies, subject to the conditions and limitations set forth in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule is designed to meet the needs of most Medicaid clients.

(b) The department shall pay for the servicing, repair or replacement of hearing aids and supplies, provided that any manufacturer's or dealer's warranty has been exhausted. The provider shall first utilize existing warranties that cover required servicing, repairs and replacement.

(c) The department shall pay for one hearing test provided by either:

(1) A hearing aid provider, who is not an audiologist; or

(2) an audiologist, ear specialist or any other physician under contract to, or employed by a hearing aid provider, who does not separately bill the department for any other hearing test or audiological examination.

Sec. 17b-262-798. Goods and services not covered

The department shall not pay providers for:

(a) Any hearing aid that is of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history;

(b) any hearing aid prescribed and ordered for a client who:

(1) Dies prior to delivery of the item; or

(2) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the item is delivered;

(c) the purchase or repair of a hearing aid necessitated by inappropriate, willful or malicious misuse on the part of the client, as determined by the department;

(d) any hearing aid or supply provided for cosmetic reasons;

(e) a hearing aid for a client in a nursing facility, ICF/MR, chronic disease hospital, hospital or other facility if the hearing aid is included in the facility's per diem Medicaid rate; or

(f) a hearing aid that can be billed to another payer.

Sec. 17b-262-799. Payment and payment limitations

(a) Fees shall be the same for in-state, border-state and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or

(4) the amount billed by the provider.

(c) The department shall reimburse a provider when all the requirements of sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies have been met.

(d) The fee for a hearing aid includes an initial one-year manufacturer's warranty against loss, theft or damage.

(e) Hearing aids provided shall be new and guaranteed against all defects in workmanship and materials for at least one year from the date of delivery of the hearing aid to the client.

(f) The department shall pay providers for:

(1) The actual acquisition cost of a hearing aid to the provider up to the maximum amount allowed by the department's fee schedule;

(2) a dispensing fee up to the maximum allowed by the department's fee schedule; and

(3) hearing testing for the purpose of fitting a hearing aid.

(g) The department shall pay for custom ear molds for a client who dies or is not otherwise eligible on the date of delivery provided the client was eligible on the date the item was ordered.

(h) If the cost of repairs to any hearing aid exceeds its replacement cost, the hearing aid shall be replaced.

(i) The provider shall meet the exact specifications of a hearing aid selected by an audiologist, ear specialist or licensed practitioner.

Sec. 17b-262-800. Prior authorization

(a) The department shall require PA for:

(1) Any hearing aid that is identified on the department's fee schedule as requiring PA;

(2) EPSDT special services; and

(3) any service or device that is not on the department's fee schedule.

(b) To receive reimbursement from the department, a provider shall comply with all prior authorization requirements. The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(c) A PA request, on a form and in the manner specified by the department, shall include documentation of medical necessity and shall be signed by the provider.

(d) A prescription is required from a licensed practitioner for all services and goods provided as EPSDT special services. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

Sec. 17b-262-801. Billing procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically transmitted to the department in a form and in a manner specified by the

department and shall include all information required by the department to process the claim for payment.

(b) A claim submitted for hearing aids and supplies that does not require prior authorization shall include the national provider identifier number of the licensed practitioner or audiologist prescribing the hearing aid, if applicable.

Sec. 17b-262-802. Documentation

(a) Providers shall maintain all fiscal and medical records related to services and goods rendered or delivered to clients.

(b) All required documentation, including evidence of a medical evaluation for a hearing aid, results of audiometric evaluations, results of any testing to support the need for a hearing aid and expected hearing improvement and notes related to fittings and adjustments shall be maintained for at least five years in the provider's primary place of business and shall be subject to review by the department.

(c) The department shall accept, when feasible, faxed or electronic medical evaluations and other orders. If evidence indicates that the documentation being reviewed has been falsified or the provider is unable to provide adequate assurance of the medical necessity of the items or services, the department may request additional information, including an original signature, in order to obtain that assurance.

(d) Any documentation, including a medical evaluation, that is electronically submitted to a vendor shall identify the sender and display the sender's fax number and date. The department may request the original medical evaluation and results of the hearing test whenever medical necessity is in question.

(e) In the event of a dispute concerning a service or a hearing aid provided, documentation shall be maintained until the end of the dispute or five years, whichever is longer.

(f) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for the hearing aid or service for which the required documentation is not maintained or provided to the department upon request.

(g) The provider shall have on file the manufacturer's purchase invoice for any hearing aid dispensed to a client, for any repairs or servicing and for any processing charges associated with replacement of a hearing aid under warranty.

(h) Providers shall maintain signed receipts for all goods and services that are provided to a client regardless of whether the item is delivered or picked up by the client or client's representative. The receipt for hearing aids, services and supplies shall at a minimum, contain the following:

(1) The provider's name;

(2) the client's name;

(3) the client's address;

(4) the date of delivery; and

(5) itemization of the hearing aid, service or supplies delivered, including, but not limited to:

(A) Product description;

(B) brand name;

(C) model name and number, if applicable;

(D) serial number, if applicable;

(E) the quantity delivered;

(F) the amount billed per hearing aid; and

(G) any warranty in effect.

(i) A prescription or order for hearing aids and supplies, regardless of the format used, shall, at a minimum, contain the following:

(1) The client's name, address and date of birth; and

(2) the diagnosis for which the hearing aid is required.

(j) Evidence of the medical evaluation shall, at a minimum, include the following:

(1) The client's name, address and date of birth;

(2) the date of the physician's medical evaluation;

(3) the prescribing physician's signature and date of his or her signature; and

(4) a statement that the client's hearing loss has been medically evaluated and that the client may be considered a candidate for a hearing aid.

(k) All required documentation shall be subject to review by authorized department personnel upon the department's request.

Sec. 17b-262-803. Other

(a) Where brand names or stock or model numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(b) The provider shall instruct the client, his or her family or a designated representative on the proper use and care of the hearing aid.

(c) The provider shall maintain a written usual and customary price list that details individual product and service charges. This list, including updates along with any required manufacturer's list pricing, shall be available for review by the department.

(d) A hearing aid purchased by the department shall become the property of the client on the date of delivery to the client.

Sec. 17-134d-83. Policy and Procedures governing oxygen therapy on behalf of Title XIX Medicaid recipients

(a) **Scope**

Section 17-134d-83 through Section 17-134d-85 of the regulations of Connecticut State Agencies governs the billing and payment for Oxygen Therapy provided to persons determined eligible for such goods and services under the provisions of Connecticut's Medical Assistance Program in accordance with Chapter 302 of the General Statutes of Connecticut.

(b) **Definitions**

For the purpose of Regulation Section 17-134d-83 through Section 17-134d-85, the following definitions apply:

"Ambulatory" means an individual who is independently mobile or wheelchair mobile and is able to participate in the active daily living available to them in their living environment.

"Chronic Disease Hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of a wide range of chronic diseases as licensed by the Department of Health Services.

"Department" means State of Connecticut Department of Income Maintenance.

"Home" means the recipient's place of residence which includes a boarding home or Home for the Aged. Home does not include a hospital or long-term care facility.

"Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions licensed by the Department of Health Services and includes inpatient psychiatric services in general hospitals.

"Long-Term Care Facilities" (LTC) are institutions licensed and certified under State law which have a provider agreement with the Department of Income Maintenance to provide a variety of medical, personal care, rehabilitative, and social services for recipients of Medical Assistance who are afflicted with acute, chronic or convalescent diseases or injuries or who because of their mental or physical condition require health-related care and services above the level of room and board which can be provided only through an institutional setting. These facilities include nursing facilities licensed as chronic and convalescent nursing homes, rest homes with nursing supervision and intermediate care facilities for the mentally retarded (ICFs/MR).

"Medical Equipment, Devices and Supplies" (MEDS) means Durable Medical Equipment, Medical Surgical Supplies, Orthotic and Prosthetic Devices and Oxygen Therapy.

"Oxygen Concentrator" means an electrically operated device that draws room air, separates the oxygen from the other gases in the air, and delivers the oxygen at high concentrations to the patient.

"Oxygen Therapy" means oxygen, equipment, supplies and services related to the delivery of oxygen.

"Oxygen Therapy Supplies" means all supplies needed for an oxygen system to function; such as cannula or mask, tubing, regulator with flow gauge and container.

"Portable Oxygen System" means oxygen in a portable unit which weighs less than 12 lbs. allowing the user greater ambulatory capability.

"Prescription" - The Certification of Medical Necessity form (Medicare Form HCFA-484) shall be the prescription form used for all oxygen therapy orders. This fully completed form signed by the prescribing physician will be the only acceptable initial certification form for oxygen services.

"Prior Authorization" (P.A.) means approval for a service from the Department of Income Maintenance before the provider actually provides the service. In order to receive approval from the Department a provider must comply with all prior authorization requirements found in Section 17-134d-84 (b) and (c). P.A. does not guarantee payment unless all other eligibility requirements are met. Payment may not be made, however, if P.A. is required and not obtained.

"Provider" means the vendor/supplier of oxygen therapy who is enrolled with the Department as a MEDS supplier or supplier of oxygen therapy.

"Pro Re Nata" (P.R.N.) means as the situation demands.

"Psychiatric Hospital" means a facility that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons and which has been accredited by the Joint Commission on Accreditation of Hospitals.

"Usual and Customary Charge to the General Public" means a charge which will be made for the particular service by the provider to the patient group accounting for the largest number of non-Medicaid services. In determining such charge, all charges made to third party payors and special discounts offered to an individual such as a senior citizen will be excluded.

(c) **Provider Participation**

In order to participate in the Medicaid program and receive payment directly from the Department all MEDS providers must:

(1) meet and maintain all applicable licensing and certification requirements of Federal and State statutes and regulations; and

(2) meet and maintain all Departmental enrollment requirements; and

(3) have a valid provider agreement on file which is signed by the provider and the Department upon application for enrollment into the Medicaid program and periodically thereafter as required by the Department and which is in effect for the period as stated in the agreement. The provider agreement specifies conditions and terms (Federal and State statutes, regulations and standards) which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(d) **Eligibility**

Payment for oxygen therapy is available for all Medicaid eligible recipients who have a documented medical need, when it is prescribed by a physician subject to the conditions and limitations which apply to these services.

(e) **Services Covered**

(1) Except for the limitations and exclusions for oxygen therapy listed below, the Department will pay in accordance with Regulation Sections 17-134d-83 through Section 17-134d-85 for oxygen therapy in accordance with sections 1861 (s) (6) and 1862 (a) (1) (A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier's Manual Chapter II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual, and as these may be amended from time to time.

(2) Payment for oxygen products and services via oxygen concentrators in LTC facilities shall be included in the per diem reimbursement rate established by the Commissioner of Income Maintenance. (LTC facilities must purchase oxygen concentrators in sufficient numbers to meet the needs of their residents and may have up to one reserve unit for each nursing station. These requirements supplement the emergency system required in the Public Health Code, as applicable.)

(f) **Service Limitations.**

Services covered are limited to those listed in the Department's fee schedule.

(g) **Oxygen Therapy Services Not Covered**

The Department will not pay for:

(1) Anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms or medical history.

(2) Oxygen therapy supplied to hospital inpatients including Chronic Disease and Psychiatric Hospitals are routine services and are included in the hospital daily rate.

(3) The P.R.N. use of oxygen therapy.

(4) Oxygen concentrators in long-term care facilities.

(A) The purchase of oxygen concentrators are included in the LTC facilities' per diem rate and thereby are available to nursing facility residents.

(B) LTC facilities with built in wall oxygen systems are exempt from the requirements pertaining to purchase of oxygen concentrators. Concentrators may not be used for P.R.N. oxygen therapy in a facility with this type of oxygen system.

(5) Information furnished to the recipient over the telephone by the provider or prescribing physician.

(6) Demurrage, delivery, or set up charges.

Sec. 17-134d-84. Policy and procedures governing the need for service for oxygen therapy on behalf of Title XIX Medicaid recipients

(a) **Need for Services**

The Department will pay for oxygen therapy for any recipient who meets the criteria established by Medicare pursuant to sections 1861 (s)(6) and 1862(a) (1)(A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier's Manual, Chapter II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual, and as they may be amended from time to time. This includes all medical criteria including medical documentation, laboratory and health conditions, with the exception of (a) (1) and (2) of this section.

(1) A measure of arterial oxygen saturation obtained by ear or pulse oximetry, will also be acceptable when ordered and evaluated by the attending physician and performed under his/her supervision or when performed by a Licensed Nurse, Physician, a licensed supplier of Laboratory services, a Registered Respiratory Therapist or a Certified Respiratory Therapy Technician as recognized by the National Board Of Respiratory Care.

(2) Those recipients residing in the home and receiving oxygen therapy prior to the effective date of this regulation may continue to do so as long as the oxygen therapy is continuous. For the purpose of this provision continuous means that oxygen therapy remains necessary and is actively being used by the recipient at the beginning of every rental month. If at anytime the service is discontinued and is prescribed again at a later time the requirements set forth under Sections 1861 (s)(6)and 1862(a)(1)(A) of the Social Security Act, 42 C.F.R. 410.38 and Medicare Carrier's Manual, Chapter II, Coverage and Limitations, Section 2100.5 including Section 60-4 in the Coverage Issues Appendix of the Medicare Coverage Issue Manual and as they may be amended from time to time must be met. All residents of longterm care facilities must meet the requirements as set forth in the Medicare Carrier's Manual, Chapter II, Coverage and Limitations, section 2100.5; and as they may be amended from time to time; effective upon passage of these regulations in order to receive oxygen therapy services from a MEDS provider. Oxygen concentrators owned by nursing facilities may be used at the discretion of the nursing facility.

(3) Prescription Requirements The Certification of Medical Necessity form (Medicare Form HCFA-484) shall be used for all orders of oxygen therapy. This fully completed form must be signed by the prescribing physician. The form shall be completed (1) annually for patients who require oxygen on a lifetime basis, and (2) every six (6) months for all other patients requiring oxygen.

(b) **Prior Authorization**

Prior authorization is required only for the rental of stationary gaseous or liquid oxygen systems in LTC facilities. However, if LTC facilities choose to purchase the stationary systems and include the cost in the per diem rate calculation, prior authorization is not required.

(c) **Prior Authorization Procedure**

Provision of service must be initiated within six (6) months of the date of authorization.

(1) Form W-619 ``Authorization Request for Professional Services" is used to obtain prior authorization. The form must be completed and signed by the prescribing physician and the supplier and is submitted to the Department.

(2) Authorization Period The initial authorization period for oxygen therapy can be up to 6 months. If the medical need continues beyond the initial authorization period, a request for the extension of the authorization using Form W-619 must be submitted to the Department with documentation by the attending physician, prior to expiration of the authorized period, that service continues to be medically necessary.

(3) The provider of service may request verbal approval from the Department during normal working hours, when such authorization may be given for initial service coverage. Authorization will be based on the Need for Service criteria as described in Section 17-134d-84 subsection (a). A completed prior authorization form must then be submitted to the Department within fifteen (15) working days stating the name of the consultant giving verbal approval and date approval was given.

(d) **Other**

(1) It will be the Department's decision to rent or purchase oxygen equipment and supplies except in cases where Medicare is the primary insurance carrier.

(2) All equipment purchased by the Department shall be new.

(3) All equipment purchased by the Department for a recipient will be the property of the recipient upon receipt by the recipient or her/his representative.

(4) The provider will furnish technical assistance to the recipient to teach the recipient and/or his or her family in the proper use and care of the equipment.

(5) Used equipment, when rented, must be completely refurbished and in proper condition to meet the recipient's specific medical need.

(6) Subject to the aforementioned limitations, exclusions, and definitions, oxygen therapy may be provided to eligible recipients in:

(A) Recipient's home;

(B) Long-term care facilities (LTC facilities will provide oxygen concentrator services to the fullest extent, possible after considering the patient's medical need and capability to ambulate. Only after these considerations have been satisfied and the need for alternative system has been documented will the Department pay a MEDS provider for oxygen services provided to LTC facility residents.)

(7) All required documentation must be maintained for at least five (5) years in the provider's file subject to review by the authorized Department personnel. This requirement survives any intervening change of ownership. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or 5 years whichever is greater.

(8) For residents of long term care facilities proper documentation for the coverage of a portable oxygen system for a particular ambulatory patient must be maintained by both the facility and the provider. The supplier should secure from the LTC facility such documentation for their records.

(9) Failure to maintain all required documentation may result in the disallowance and recovery by the Department of any amounts paid out for which the required documentation is not maintained and provided to the Department upon request. (Effective May 27, 1992)

Sec. 17-134d-85. Policy and procedures governing the billing and payment for oxygen therapy on behalf of title XIX Medicaid recipients

(a) **Billing Procedure**

(1) Form H.C.F.A. 1500 ``Health Insurance Claim Form'' is used to bill for oxygen therapy. The bill is mailed to the Department's claims processing agent.

(2) All claims submitted for payment which include prior authorized items must include the authorization number from the current authorization.

(3) All claims submitted for services not requiring prior authorization must include the name of the prescribing physician.

(4) The provider shall enter its usual and customary charge on the claim form.

(b) **Payment**

Payment for oxygen therapy will be made at the lower of:

(1) the usual and customary charge to the public, or

(2) the amount as contained in the fee schedule as published by the Department, or

(3) the amount billed by the provider.

(c) **Payment Rate for Oxygen Therapy**

The Commissioner of Income Maintenance establishes the oxygen therapy rate as contained in the Department's fee schedule.

(d) **Payment Limitations**

(1) All prices quoted for equipment and services include delivery costs fully prepaid by the provider, F.O.B. destination; no additional charges are to be made for packing, shipping, or delivery to the recipient.

(2) If the estimated cost of repairs to any equipment exceeds replacement cost, the item will be replaced.

(3) Payment for repairs or replacement of equipment which is purchased by the Department is contingent upon any unexpired manufacturers or dealer warranties. The supplier must first utilize existing warranties covering such servicing, repairs, and replacement.

(4) The cost of oxygen therapy includes all services and supplies necessary including, but not limited to: (1) installation and/or set up of prescribed equipment; (2) teaching and training the recipient, recipient's family, and long-term care facility professional staff in the use and care of the equipment as shall be necessary; (3) oximetry test.

(5) The rental fee for the delivery of oxygen therapy includes a nasal cannula, mask, and disposable humidifier as needed. (Effective May 27, 1992)

Requirements for Payment of Durable Medical Equipment

Sec. 17b-262-672 Scope

Sections 17b-262-672 through 17b-262-682 of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of durable medical equipment (DME) to providers, for clients who are determined eligible to receive services under Connecticut Medicaid pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

Sec. 17b-262-673 Definitions

For the purposes of sections 17b-262-672 through 17b-262-682 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) "Chronic disease hospital" means an institution as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Certificate of Medical Necessity" or "CMN" means an approved Medicare form or a similar form which has been submitted to and approved by the department for use. This form shall contain all the documentation required for DME;

(4) "Commissioner" means the commissioner of social services;

(5) "Customized equipment" means devices or equipment prescribed by a licensed practitioner which is specifically manufactured to meet the special medical, physical, and psychosocial needs of the client. The equipment shall be individualized to preclude its use by any other person except the client for whom it was originally developed;

(6) "Department" means the department of social services or its agent;

(7) "Documented in writing" means that the prescription has been handwritten, typed, or computer printed;

(8) "Durable medical equipment" or "DME" means equipment that meets all of the following requirements:

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to a person in the absence of an illness or injury; and

(D) is nondisposable;

(9) "Equipment replacement" means any item that takes the place of original equipment lost, destroyed, or no longer medically useable or adequate;

(10) "Home" means the client's place of residence which includes a boarding home, community living arrangement, or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), or other facilities that are paid an all inclusive rate directly by Medicaid for the care of the client;

(11) "Hospital" means an institution as defined in Section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(12) "Intermediate care facility for the mentally retarded" or "ICF/MR" means an institution licensed by, or operated by, the department of mental retardation (DMR) according to state law, and certified as a Medicaid intermediate care facility for the mentally retarded by the department of public health (DPH) to provide health or rehabilitative services for individuals with mental retardation or related conditions who, because of their mental or physical condition, require care and services, above the level of room and board, which can be made available to them only through a residential facility. Individuals residing in an ICF/MR shall be receiving active treatment pursuant to 42 CFR 483.440(a);

(13) "Licensed practitioner" means any person licensed by the state of Connecticut, any other state, District of Columbia, or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(14) "Manufactured" means constructed or assembled;

(15) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(16) "Medicaid" means the program operated by the department of social services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(17) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(18) "Nursing facility" or "NF" means an institution as defined in 42 USC 1396r(a);

(19) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed by the practitioner issuing the order;

(20) "Prior authorization" or "PA" means approval for the service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(21) "Provider" means the vendor or supplier of durable medical equipment who is enrolled with the department as a medical equipment, devices, and supplies supplier; and

(22) "Provider agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

Sec. 17b-262-674 Provider Participation

In order to enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

Sec. 17b-262-675 Eligibility

Payment for DME and related equipment is available for Medicaid clients who have a medical need for such equipment which meets the department's definition of DME when the item is prescribed by a licensed practitioner, subject to the conditions and limitations set forth in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies.

Sec. 17b-262-676 Services Covered and Limitations

(a) Services Covered

(1) The department shall pay for the purchase or rental and the repair of DME, except as limited by sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, that conforms to accepted

methods of diagnosis and treatment and is medically necessary and medically appropriate.

(2) DME services are available to all clients who live at home. Additionally, the department shall pay for ventilators, customized wheelchairs, and Group 2 Pressure Reducing Support Surfaces for residents of nursing facilities and ICFs/MR.

(3) The department shall maintain a non-exclusive fee schedule of items which it has already determined meet the department's definition of DME and for which coverage shall be provided to eligible clients, subject to the conditions and limitations set forth in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule includes, but is not limited to:

(A) wheelchairs and accessories;

(B) walking aides, such as walkers, canes, and crutches;

(C) bathroom equipment such as commodes and safety equipment;

(D) inhalation therapy equipment such as IPPB machines, suction machines, nebulizers, and related equipment;

(E) hospital beds and accessories; and

(F) enteral/parenteral therapy equipment.

(4) When the item for which Medicaid coverage is requested is not on the department's fee schedule, prior authorization is required by the department. The recipient requesting Medicaid coverage for a prescribed item not on the list shall submit such prior authorization request to the department through an enrolled provider of DME. Such request shall include a signed prescription and shall include documentation showing the recipient's medical need for the prescribed item. If the item for which Medicaid coverage is requested is not on the department's fee schedule, the provider shall also include documentation showing that the item meets the department's definition of DME and is medically appropriate for the client requesting coverage of such item.

(5) In the last quarter of each calendar year, the department shall make modifications to its non-exclusive DME fee schedule. In deciding which items to add to this schedule, the department shall give consideration to:

(A) items requested for individual consideration through the process described in subdivision (4) of this subsection;

(B) input from the provider community; and

(C) input from the consumer community. Providers and consumers who wish to provide input may make suggestions to the department's Medical Operations unit. Any suggestions shall be considered during the department's annual modification of its fee schedule.

(b) Limitations

(1) The department shall not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms, or medical history.

(2) Notwithstanding any other provisions of the Regulations of Connecticut State Agencies, the department shall pay for customized wheelchairs for clients of nursing facilities and ICFs/MR only when such customized wheelchairs are medically necessary in accordance with section 17-134d-46 or section 17-134d-47 of the Regulations of Connecticut State Agencies. The department shall pay for the purchase, modification or repair of these customized wheelchairs. The customized wheelchair may or may not be motorized. The need for the customized wheelchair shall be documented in accordance with section 17-134d-46 or section 17-134d-47 of the Regulations of Connecticut State Agencies.

Sec. 17b-262-677 Services Not Covered

The Department shall not pay DME providers for:

(1) standard or stock DME items prescribed and ordered for a client who:

(A) dies prior to delivery of the item, or

(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the item is delivered;

(2) the purchase or repair of DME necessitated by inappropriate, willful, or malicious misuse on the part of the client as determined by the department;

(3) the repairs and maintenance of DME furnished on a rental basis. The rental fee shall cover the services necessary to maintain the equipment in working order;

(4) DME supplied to clients in hospitals or chronic disease hospitals; and

(5) any service or item not identified as covered in sections 17b-262-672 to 17b¬262-682, inclusive, of the Regulations of Connecticut State Agencies, unless it is approved in accordance with section 17b-262-676(a)(4) of the Regulations of Connecticut State Agencies.

Sec. 17b-262-678 Prior Authorization

(a) In order to receive reimbursement from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(b) The department requires prior authorization for: 1) any item identified on the department's published fee schedule as requiring prior authorization; and 2) any item requested under section 17b-262-676(a)(4) of the Regulations of Connecticut State Agencies.

(c) A PA request, on forms and in a manner as specified by the department, shall include documentation of medical need and shall be signed by the prescribing licensed practitioner and the supplier. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and subject to review by the department.

(d) A provider may FAX in prior authorization requests that are medically necessary to: 1) facilitate institutional discharge, or 2) avoid imminent hospitalization. Specifics that substantiate the nature of the request need to be clearly documented. Other PA requests for DME shall be submitted by mail.

(e) The initial authorization period for the rental of DME is determined by the department. If the medical need continues beyond the initial authorization period, a request for the extension of the authorization shall be submitted to the department with documentation by a licensed practitioner that service continues to be medically necessary. Such request and documentation shall arrive at the department prior to the start date of the extension or prior authorization shall be denied.

(f) Providers shall include an estimated delivery date when submitting a request for prior authorization, allowing for the department to take up to four weeks to process the request. The department shall share such estimated date with the client so that expectations for service delivery can be clear. Prior authorizations that do not include an estimated delivery date shall be denied.

Sec. 17b-262-679 Billing Procedure

(a) Claims from DME providers shall be submitted on a hard copy invoice or electronically transmitted to the department or its agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.

(b) Claims submitted for DME not requiring prior authorization shall include the name of the licensed practitioner or clinic making the referral. A licensed practitioner's original prescription for these items shall be on file with the provider and shall be subject to review by the department.

(c) DME providers shall bill and the department shall pay at the lowest of:

(1) the usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount prior authorized in writing by the department; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(d) Notwithstanding the provisions of subsection (c)(5) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual without affecting the amount paid by the department for the same or substantially similar goods or services.

Sec. 17b-262-680 Payment Limitations

(a) Payment shall be made for customized DME for a client who dies or is not otherwise eligible on the date of delivery providing the client was eligible:

(1) on the date prior authorization was given by the department; or

(2) on the date the client ordered the item, if the item does not require prior authorization. For purposes of this section, the date the client orders the

item means the date on which the written medical order for the item is presented to the provider. The provider shall verify to the department the date the client ordered the item.

(b) If the cost of repairs to any item exceeds its replacement cost, the item shall be replaced.

(c) The price for any item listed in the fee schedule published by the department shall include:

(1) fees for initial fittings and adjustments and related transportation costs;

(2) labor charges;

(3) delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional charges to be made for packing or shipping;

(4) travel to the client's home, postage and handling, and set up or installation charges;

(5) technical assistance to the client to teach the client, or his or her family, the proper use and care of the equipment; and

(6) information furnished by the provider to the client over the telephone.

(d) Payment for servicing, repairs, or replacement of DME that are purchased by the department shall be contingent upon the exhaustion of any manufacturer's or dealer's warranty. The supplier shall first utilize existing warranties covering required servicing, repairs, and replacement.

(e) The department may pay for the rental of a wheelchair, for a period not to exceed three (3) months, in situations involving the pending delivery of a customized model to a client who resides in his or her own home.

(f) The department has the authority to determine the maximum rental period for DME, at which time the item shall be considered purchased. Such maximum rental periods shall be published on the fee schedule.

Sec. 17b-262-681 Documentation

(a) All required documentation shall be maintained for at least five (5) years in the DME provider's file subject to review by the department. In the event of a dispute concerning a service or an item provided, documentation shall be maintained until the end of the dispute or five (5) years, whichever is greater.

(b) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the DME provider for the item or service for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for DME shall be on file with the DME provider and shall be subject to review by the department. Such prescription shall specify the items ordered.

(d) The department requires that DME providers maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid clients. A new prescription is required prior to replacement of DME.

(e) A signed receipt is required for all deliveries of DME, documenting that the client or, if the client is unable to sign, a designated representative other than the DME provider or the DME provider's employees, took delivery of the item. The receipt for DME, regardless of format used, shall, at a minimum, contain the following elements:

(1) provider's name;

(2) client's name;

(3) itemization of DME delivered, including:

(A) product description;

(B) brand name;

(C) model name and number;

(D) serial number (if applicable);

(E) quantity delivered; and

(F) amount billed per item; and

(4) date of delivery.

(f) All prescriptions for DME regardless of format used (e.g., CMN, prescription pad, or letter) shall, at a minimum, contain the following elements:

(1) the client's name, address, and date of birth;

(2) diagnosis for which the DME is required;

(3) detailed description of the DME, including quantities and any special options or add-ons;

(4) length of need for the DME use;

(5) name and address of prescribing practitioner; and

(6) prescribing practitioner's signature and date signed.

(g) All requests for purchase of DME to replace an item shall be fully explained, documenting the continuing medical necessity and including reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement.

Sec. 17b-262-682 Other

(a) All equipment or devices purchased by the department shall be new and shall become the property of the client as of the date of delivery to the client.

(b) Where brand names or stock or model numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(c) Used equipment when rented shall be completely refurbished and in proper condition to meet the client's specific medical need.

(d) The provider shall instruct the client, or his or her family, on the proper use and care of the equipment. This instruction shall be provided as a part of the cost of the item. Additionally, the services and items shall be appropriate to both the environment and the client's current medical necessity.

(e) When the DME item is delivered, the provider shall ensure that proper assembly occurs and that the item meets the client's needs.

(f) DME providers shall notify the department of returns of DME items delivered to a client. Providers shall initiate necessary reimbursement adjustments resulting from such returns.

(g) It shall be the department's decision to rent or purchase DME, except in cases where the rental or payment option is determined by the primary payor source.

REGULATIONS OF CONNECTICUT STATE AGENCIES DEPARTMENT OF SOCIAL SERVICES Concerning Requirements for Payment to Providers of Orthotic and Prosthetic Devices

Section 1. The Regulations of Connecticut State Agencies are amended by adding sections 17b¬262-736 to 17b-262-746, inclusive, as follows:

Section 17b-262-736. Scope

Sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to providers of orthotic and prosthetic devices that are prescribed by a licensed practitioner on behalf of clients who are determined to be eligible to receive such goods and services under Medicaid pursuant to section 17b-262 of the Connecticut General Statues.

Section 17b-262-737. Definitions

As used in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Chronic disease hospital" means a "chronic disease hospital" as defined in section 19-13¬D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Customized orthotic or prosthetic device" means a device prescribed by a licensed practitioner that is specifically manufactured to meet the special medical, physical or psychosocial needs of a client. A customized orthotic or prosthetic device requires special construction, the plans for which are taken from an exact model of a particular client's body part;

(4) "Department" means the Department of Social Services or its agent;

(5) "Documented in writing" means that the prescription has been handwritten, typed or computer printed;

(6) "Home" means the client's place of residence and includes a boarding home, community living arrangement or residential care home. Home does not include a facility such as a hospital, chronic disease hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(7) "Hospital" means a "short-term hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(8) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(9) "Licensed practitioner" means an individual who is either licensed by the Connecticut Department of Public Health, another state, District of Columbia or the Commonwealth of Puerto Rico and is acting within his or her scope of practice under Connecticut state law in prescribing an orthotic or prosthetic device;

(10) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally-recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(11) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(12) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness, to assist an individual in attaining or maintaining an optimal level of health, to diagnose a condition or to prevent a medical condition from occurring;

(13) "Nursing facility" means an institution as defined in 42 USC 1396r(a), as amended from time to time;

(14) "Orthotic or prosthetic device" or "device" means a corrective or supportive device prescribed by a licensed practitioner, within the scope of his or her practice as defined by federal and state law, to:

(A) artificially replace a missing portion of the body;

(B) prevent or correct physical deformity or malfunction; or

(C) support a weak or deformed portion of the body;

(15) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed and dated by the licensed practitioner issuing the order;

(16) "Prior authorization" or "PA" means approval from the department for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(17) "Provider" means the vendor or supplier of an orthotic or prosthetic device who is enrolled with the department as a medical equipment, devices, and supplies supplier; and

(18) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Section 17b-262-738. Provider Participation

To enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

Section 17b-262-739. Eligibility

A provider may receive reimbursement from the department for the provision of an orthotic and prosthetic device to a client. No reimbursement shall be made unless a licensed practitioner has prescribed the orthotic or prosthetic device subject to the conditions and limitations set forth in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies.

Section 17b-262-740. Services Covered and Limitations

(a) Services Covered

(1) The department shall pay for the purchase or repair of a medically necessary and medically appropriate orthotic or prosthetic device, except as limited by sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies, provided such device is prescribed by a licensed practitioner in conformance with accepted methods of diagnosis and treatment.

(2) The department shall pay for an orthotic or prosthetic device for a client who lives at home or in a nursing facility, ICF/MR, hospital or chronic disease hospital, except as limited by sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies.

(3) The department shall maintain a fee schedule for orthotic and prosthetic devices, subject to the conditions and limitations set forth in sections 17b-

262-736 to 17b¬262-746, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule is designed to meet the needs of most Medicaid clients. An item is not covered unless it is on the fee schedule. A provider or client may request that an item be added to the fee schedule. The department, at its discretion, may decide to add requested items during its regular revisions to the fee schedule, as published by the department.

(4) The department shall pay for early and periodic screening, diagnostic and treatment services (EPSDT) described in subsection 1905(r) of the Social Security Act, as amended from time to time.

(b) Limitations

(1) The department shall pay for replacement of a device only if the device is lost, destroyed or is no longer medically usable or adequate due to a measurable change in the client's condition. A new prescription shall be required for a replacement item. All requests for purchases of orthotic or prosthetic devices to replace a device shall be fully explained, and shall document the continuing medical necessity and include reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement.

(2) The department shall not pay for an orthotic or prosthetic device for a client in a nursing facility, ICF/MR, chronic disease hospital or hospital if the device is included in the facility's per diem Medicaid rate.

(3) The department shall not pay for an orthotic or prosthetic device that can be billed to another payor.

Section 17b-262-741. Goods and Services Not Covered

The department shall not pay providers for:

(1) any orthotic or prosthetic device that is of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history;

(2) any non-customized orthotic or prosthetic device that does not require prior authorization and that is prescribed and ordered for a client who:

(A) dies prior to delivery of the device; or

(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the device is delivered; or

(3) the purchase or repair of an orthotic or prosthetic device necessitated by inappropriate, willful or malicious misuse on the part of the client as determined by the department.

Section 17b-262-742. Prior Authorization

(a) The department shall require PA for any orthotic or prosthetic device identified on the department's published fee schedule as requiring PA.

(b) To receive reimbursement from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(c) A PA request, on a form and in a manner specified by the department, shall include documentation of medical necessity and shall be signed by the prescribing licensed practitioner and the provider. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

(d) A provider may send a prior authorization request to the department via facsimile if the request is medically necessary to: (1) facilitate institutional discharge or (2) avoid imminent hospitalization. Specifics that substantiate the nature of the request shall be clearly identified in the facsimile. All other PA requests for an orthotic or prosthetic device shall be submitted by mail.

Section 17b-262-743. Billing Procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically transmitted to the department or its agent in a form and in a manner specified by the department and shall include all information required by the department to process the claim for payment.

(b) A claim submitted for an orthotic or prosthetic device that did not require prior authorization shall include the name of the licensed practitioner prescribing the device. A licensed practitioner's original prescription for the device shall be on file with the provider and shall be subject to review by the department.

(c) Providers shall bill and the department shall pay at the lowest of:

(1) the usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider to the department; or

(5) the amount the department indicates in writing in a prior authorization.

Section 17b-262-744. Payment Limitations

(a) The department shall reimburse a provider when all requirements of sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies have been met.

(b) The department shall pay for a customized orthotic or prosthetic device for a client who dies or is not otherwise eligible on the date of delivery provided the client was eligible:

(1) on the date prior authorization was given by the department; or

(2) on the date the client ordered the device, if the device does not require prior authorization. For purposes of this section, the date the client orders the device means the date on which the written medical order for the device is presented to or received by the provider. The provider shall verify to the department the date the client ordered the device.

(c) If the cost of repairs to any orthotic or prosthetic device exceeds its replacement cost, the device shall be replaced.

(d) The price for any device listed in the fee schedule published by the department shall include:

(1) fees for initial fittings and all related subsequent adjustments;

(2) labor charges;

(3) delivery costs, fully prepaid by the provider, including any manufacturer's delivery charges, postage, packing and shipping;

(4) all travel costs incurred by the provider associated with measurements, fittings, adjustments or repairs;

(5) technical assistance fees related to teaching the client, his or her family or the designated representative the proper use and care of the equipment; and

(6) fees for providing information to the client over the telephone.

(e) The department shall pay for the servicing, repair or replacement of an orthotic or prosthetic device that is purchased by the department, provided that any manufacturer's or dealer's warranty has been exhausted. The provider shall first utilize existing warranties that cover required servicing, repairs and replacement.

Section 17b-262-745. Documentation

(a) All required documentation shall be maintained for at least five (5) years in the provider's primary place of business and shall be subject to review by the department. In the event of a dispute concerning a service or a device provided, documentation shall be maintained until the end of the dispute or five (5) years, whichever is longer.

(b) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for the device or service for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for an orthotic or prosthetic device and documentation of all notes related to fittings and adjustments shall be kept at the provider's primary place of business and shall be subject to review by the department.

(d) Providers shall maintain all fiscal and medical records related to services and goods rendered or delivered to Medicaid clients.

(e) Providers shall require and retain a signed receipt for all deliveries of orthotic and prosthetic devices, documenting that the client or, if the client is unable to sign, a designated representative other than the provider or the provider's employee, took delivery of the device. The receipt for an orthotic or prosthetic device, regardless of the format used, shall, at a minimum, contain the following elements:

(1) the provider's name;

(2) the client's name;

(3) the delivery address;

(4) the date of delivery; and

(5) itemization of the orthotic and prosthetic devices delivered, including:

(A) a product description;

(B) a brand name;

(C) a model name and number, if applicable;

(D) a serial number, if applicable;

(E) the quantity delivered; and

(F) the amount billed per device.

(f) A prescription for an orthotic or prosthetic device, regardless of the format used, shall, at a minimum, contain the following elements:

(1) the client's name, address and date of birth;

(2) the diagnosis for which the orthotic or prosthetic device is required;

(3) a detailed description of the orthotic or prosthetic device, including the quantity and any special options or add-ons, and, if needed, directions for usage;

(4) the length of need for the orthotic or prosthetic device prescribed;

(5) the name and address of the prescribing licensed practitioner; and

(6) the prescribing licensed practitioner's signature and date of his or her signature.

Section 17b-262-746. Other

(a) Where brand names or stock or model numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(b) The provider shall instruct the client, his or her family or a designated representative on the proper use and care of the device.

(c) Providers shall initiate necessary reimbursement adjustments to the department resulting from returns of non-customized orthotic and prosthetic devices delivered to a client.

(d) The provider shall maintain a written usual and customary price list that details individual product and service charges. This list, including updates along with any required manufacturer's list pricing, shall be available for review by authorized department personnel.

(e) An orthotic or prosthetic device purchased by the department shall be new and shall become the property of the client on the date of delivery to the client.