DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-F: Changes to Physician Office and Outpatient, Physician Radiology, and Independent Radiology Fee Schedules

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

Changes to Medicaid State Plan

Effective on or after February 1, 2018, SPA 18-F will amend Attachment 4.19-B of the Medicaid State Plan to make changes on the physician office and outpatient, physician radiology, and independent radiology fee schedules as described below. The physician radiology and independent radiology fee schedules will be revised to ensure the rates for the codes on those fee schedules are consistent with the standard reimbursement methodology of 57.5% of the 2007 Medicare fee schedule if the code was in effect at that time or 57.5% of the applicable year of the Medicare fee schedule coinciding with the initial activation of the procedure code.

This SPA will also incorporate the deletion of select Current Procedure Terminology (CPT) codes from the Physician Office and Outpatient Services fee schedule. Specifically, the following CPT codes are being end-dated or deleted from the physician office and outpatient fee schedule in order to be consistent with Medicaid regulations and coverage policies:

- CPT code 96040 (Genetic counseling, 30 minutes) when billed by a genetic counselor, which is not an enrollable provider type under the HUSKY Health provider network. Any service performed by a genetic counselor is not eligible for HUSKY Health reimbursement because genetic counselors are not categorized as an allied health professional, and they cannot render services under the supervision of a health professional.
- CPT code 97607 (Neg press wnd tx </=50 sq cm, non-durable) and CPT 97608 (Neg press wound tx >50 cm, non-durable) when billed as a professional service when a disposable wound vacuum is used. A disposable wound vacuum is classified as non-durable medical equipment which is not covered under the Connecticut Medical Assistance Program (CMAP). The Healthcare Common Procedure Coding System (HCPCS) codes for disposable wound vacuum will not be added to the durable medical equipment (DME) fee schedule. In order to be consistent, the CPT codes (97607 and 97608) for the professional service attached to the disposable wound vacuum are being deleted from the physician office and outpatient

fee schedule since the HCPCS code for the wound vacuum will not be added to this fee schedule.

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

Fiscal Information

DSS estimates that the updates to the physician-radiology and independent radiology fee schedules will increase annual aggregate Medicaid expenditures for independent radiology and physician radiology by approximately $7,800 in State Fiscal Year (SFY) 2018 and $19,200 in SFY 2019.

DSS estimates that the deletion of specified procedure codes from the physician office and outpatient fee schedule will result in a nominal decrease of gross Medicaid expenditures by approximately $1,000 in SFY 2018 and $3,000 in SFY 2019.

Obtaining SPA Language and Submitting Comments

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

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference "SPA 18-F: Changes to Physician Office and Outpatient, Physician Radiology, and Independent Radiology Fee Schedules".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than February 14, 2018.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

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(3) Other Laboratory and X-ray Services –The fee schedules and any adjustments to the fee schedules are published in www.ctdssmap.com. Fees are effective as of the date noted below, except that fees may be deleted or added and priced in order to remain compliant with HIPAA or to correct pricing errors. Laboratory and X-ray service fees are the same for both governmental and private providers.

- Laboratory Services were set as of February 1, 2018. The Department reviews Medicare rate changes annually to ensure compliance with federal requirements.
- X-ray services provided by independent radiology centers were set as of January 1, 2018. Select the "Independent Radiology" fee schedule, which displays global fees, including both the technical and professional components of each fee.

(5) Physician's services – Fixed fee schedule not to exceed the Medicare physician fee schedule. The current fee schedule was set as of February 1, 2018 and is effective for services provided on or after that date. The fee schedule for physicians can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." All governmental and private providers are reimbursed according to the same fee schedule.

Person-Centered Medical Home (PCMH) practices are individual sites of independent physician groups, solo physician practices, nurse practitioner groups, and individual nurse practitioners that have met National Committee for Quality Assurance (NCQA) Level 2 or Level 3 medical home recognition or NCQA medical home recognition under the 2017 or later NCQA standards (which do not recognize specific levels of recognition). PCMH practices must comply with all NCQA PCMH requirements and all additional written department requirements, including participation in various primary care initiatives operated by the State.

The department offers a PCMH Glide Path program, which pays enhanced rates to practices that are providing some of the additional Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must demonstrate that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA PCMH recognition in a set period of time. Glide Path practices must also comply with all additional written department requirements, including participation in various primary care initiatives operated by the State.

Beginning January 1, 2012, PCMH and Glide Path practices may be eligible for a rate add-on to the procedure codes on the physician fee schedule identified below. PCMH practices may also be eligible for retrospective annualized supplemental payments for performance incentives and performance improvement. Independent physician-led Glide Path practices with five or fewer full-time equivalent practitioners across all practice locations may also be eligible for a supplemental payment at each Glide Path phase.

(a) Glide Path and PCMH Rate Add-On: The department will pay a rate add-on for the following procedures in addition to the amounts listed for each procedure code on the physician fee schedule: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99374, 99377, 99379, 99380, 96110, 99050, 99051, 99053, D0145,