

Legislative Regulation Review Committee

2009-016

Department of Social Services

**REQUIREMENTS FOR PAYMENT OF
MEDICAL & SURGICAL SUPPLIES**

IMPORTANT: Read instructions on bottom of Certification Page before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations.

REGULATION

OF

NAME OF AGENCY

Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION

Payment of Medical and Surgical Supplies

SECTION _____

Statement of Purpose: (A) The purpose of the proposed regulation is: to adopt requirements, in regulation form, for the payment of medical and surgical supplies provided to clients in the Medicaid program. The problems, issues or circumstances that the regulation proposes to address are: (1) to update requirements for payment of medical and surgical supplies to reflect current policy and practice, and (2) to set forth the department's Medical Services Policy regarding coverage and payment of medical and surgical supplies in regulation form. The new regulation incorporates current policy and practice, deletes antiquated limitations and provides correct guidance on billing and documentation requirements.

(B) The main provisions of the regulation: (1) provide necessary definitions; (2) provide requirements for provider participation; (3) provide the medical and surgical supplies covered and the limitations on coverage of those supplies; (4) set forth the circumstances under which prior authorization is required; (5) provide billing procedures and payment limitations; and (6) provide documentation requirements.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws are: to put the requirements for payment of medical and surgical supplies, currently only found in the Medical Services Policy, into regulation form.

CERTIFICATION

R-39 REV. 1/77

Be it known that the foregoing:

Regulations Emergency Regulations

Are:

Adopted Amended as hereinabove stated Repealed

By the aforesaid agency pursuant to:

Sections 17b-262 and 17b-239b of the General Statutes.

Section _____ of the General Statutes, as amended by Public Act No. _____ of the _____ Public Acts.

Public Act No. _____ of the Public Acts.

After publication in the Connecticut Law Journal on August 5, 2008, of the notice of the proposal to:

Adopt Amend Repeal such regulations

(If applicable): And the holding of an advertised public hearing on 22 day of September

WHEREFORE, the foregoing regulations are hereby:

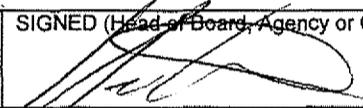
Adopted Amended as hereinabove stated Repealed

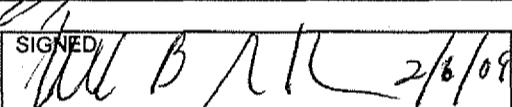
Effective:

When filed with the Secretary of the State.

(OR)

The _____ day of _____.

In Witness Whereof:	Date	SIGNED (Head of Board, Agency or Commission)	OFFICIAL TITLE, DULY AUTHORIZED
	<u>11/10/09</u>		Commissioner

Approved by the Attorney General as to legal sufficiency in accordance with sec. 4-169, as amended C.G.S.	SIGNED	OFFICIAL TITLE, DULY AUTHORIZED
	 <u>2/6/09</u>	ASSOC. ATTY. GENERAL

- Approved
- Disapproved
- Disapproved in part, (Indicate Section Numbers disapproved only)
- Rejected without prejudice

By the Legislative Regulation Review Committee in accordance with Sec. 4-170, as amended, of the General Statutes.	Date	SIGNED (Clerk of the Legislative Regulation Review Committee)

Two certified copies received and filed, and one such copy forwarded to the Commission in Official Legal Publications in accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State.)	BY

INSTRUCTIONS

- One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.
- Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.
- Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.
- Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capital letters and deleted language in brackets. Section 4-170 of the General Statutes.

R-39 REV. 04/04
IMPORTANT: Read
instructions on bottom of
Certification Page before
completing this form.
Failure to comply with
instructions may cause
disapproval of proposed
Regulations.

STATE OF CONNECTICUT
REGULATION
OF

Name of Agency

Department of Social Services

Subject Matter of Regulation

Requirements for Payment for Medical and Surgical Supplies

Section 1. The Regulations of the Connecticut State Agencies are amended by adding sections 17b-262-712 to 17b-262-722, inclusive, as follows:

(NEW) 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 that are prescribed by a licensed practitioner and provided to clients who are determined to be eligible to receive such supplies under the Connecticut Medicaid Program pursuant to section 17b-26 of the Connecticut General Statutes.

(NEW) 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 special services" means services provided in accordance with subdivision 1905(5)(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;
- (11) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-26 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;
- (12) "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;
- (13) "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;
- (14) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;
- (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 before the provider actually provides the service or delivers the goods;
- (17) "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;
- (18) "Provider agreement" means the signed, written contractual agreement between the department and the provider; and
- (19) "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.

(NEW) 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.

(NEW) 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 the Connecticut State Agencies.

(NEW) 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 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 Medicaid coverage is requested is not on the department's fee schedule, prior authorization is required for that supply. The provider requesting payment Medicaid 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 for no longer than one year.
- (3) The department may set maximum allowable quantity limitations at levels determined 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.

(NEW) 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.

(NEW) 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.

(NEW) 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 as specified by the department, and shall include all information required by the department 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 of 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 and 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 usual and customary charge; or
- (4) the amount prior authorized in writing by the department.

(NEW) Sec. 17b-262-720. Payment limitations

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

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

(NEW) 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 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.

(NEW) 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.

Sec. 2. Sections 188 to 188 J.I., inclusive, of the department's Medical Services Policy for medical and surgical supplies, which have the force of regulation pursuant to section 17b-10 of the Connecticut General Statutes are repealed.

Statement of Purpose: The Department of Social Services is revising its medical and surgical supplies policy in order to make technical changes, add definitions as necessary and incorporate current policy and practice. Changes include: 1) adding definitions as necessary 2) incorporating current practice; and 3) clarifying the prior authorization process, documentation requirements and the billing procedures.