



February 26, 2013

Regarding: Public Hearing on Governor's Bill 6367

Dear Human Services Committee Members,

The National Coalition for Assistive & Rehab Technology (NCART) is an organization comprised of companies that manufacture and provide customized wheelchairs and other specialized equipment for Connecticut citizens who are in great need of our products and services for their health, welfare and safety.

Two Connecticut based companies, ATG Rehab of Rocky Hill and Hudson Seating & Mobility of Newington, are members of NCART and on their behalf we are respectfully requesting that the following information be shared with the Human Services Committee and submitted into the record:

We support the changes proposed in **Section 25 of Governor' Bill 6367 – An Act Implementing the Governor's Budget Recommendations for Human Services Programs**. By way of background, Section 8 of the December 2012 Deficit Mitigation bill, HB 7001, changed the assessment and approval process for nursing facility residents who may need Customized Wheelchair products and services. Now, Section 25 of Governor's Bill 6367, appropriately amends that provision to delete the text stating: *"Assessment of the need for a customized wheelchair may be performed by a vendor or nursing facility only if specifically requested by the Department [of Social Services]."* Section 25 provides that assessments should continue to be performed even if they are not "specifically requested" by the Department. This is an appropriate change and we respectfully request the members of the Human Services Committee to support this change.

VERY IMPORTANTLY: More generally with respect to the provision of customized wheelchair products and services to Connecticut's vulnerable citizens, the **Governor's Budget Bill 6350**, contains a "financial" proposal under which the Connecticut Department of Social Services (DSS) would save \$4.5M in both FY14 and FY15 by revising the approval process for Customized Wheelchairs in nursing facilities. This represents a very large cut in current spending for customized wheelchairs for residents of nursing facilities.

Additionally, we have attached hereto a copy of Page 1 of a February 2013 DSS Policy Bulletin No. 2013-09 that states:

*"Purchase: the Department has reduced its fees for most codes on the Durable Medical Equipment (DME) and Orthotic and Prosthetic Devices (O&P) fee schedules and some codes on the Medical Surgical Supplies (MSS) fee schedule **by 5%**.*

*Repairs: Repairs to most of these codes have been re-priced at **60% of the purchase price**. Providers are required to bill repairs at 60% of the purchase price or MSRP minus 15%, **whichever is lower**" (emphasis added).*



Respectfully, the cumulative effect of the huge cuts in the Budget Proposal – coupled with the cuts contained within the DSS Policy Bulletin – will definitely create chaos in our industry – and our disabled and vulnerable clients will suffer the consequences of these drastic cumulative cuts. That’s not fair to them.

Although NCART member companies are always more than happy to work with DSS professionals to identify opportunities where savings and efficiencies can be identified and implemented over time, we respectfully contend that too many cuts are being made that may impact the providers’ ability to effectively service the Medicaid members’ complex rehab technology needs. We don’t want our clients – who always have very significant physical and medical challenges – to suffer needlessly in the process. Additionally, we have many families who depend upon employment with our companies in Rocky Hill and Newington, and we want them to keep working for us.

We are hoping to continue our open dialogue with DSS and with the Connecticut Legislature regarding the importance of customized wheelchair products and services for Connecticut citizens who have very significant physical and medical challenges. In almost all cases, a person who has access to a customized wheelchair is far less likely to have severe medical and health complications that would then require the person to seek much more expensive care in a hospital setting.

Thank you very much for your consideration of our position on issues relating to customized wheelchairs.

Sincerely,

A handwritten signature in black ink that reads "Don Clayback".

Donald E. Clayback

Executive Director

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Connecticut Medical Assistance Program
Policy Transmittal 2013-04

PB 2013-09
February 2013

Roderick L. Bremby, Commissioner

Effective Date: March 1, 2013

Contact: Ginny Mahoney @ 860-424-5145

TO: Medical Equipment Devices and Supplies (MEDS) Providers

RE: Updated MEDS Fee Schedule and Reimbursement

Effective for dates of service on or after March 1, 2013, the Department of Social Services is revising its fee schedule for Medical Equipment, Devices and Supplies (MEDS). Changes include the addition, deletion and description changes for codes on the MEDS fee schedule consistent with Healthcare Common Procedure Coding System (HCPCS) updates. Additions and deletions are necessary to ensure that the MEDS fee schedule remains compliant with the Health Insurance Portability and Accountability Act (HIPAA). These changes apply to all MEDS reimbursed under the HUSKY Health program which includes HUSKY A, HUSKY B, HUSKY C, HUSKY D and the Charter Oak Health program.

Reduction in fees to codes on the MEDS fee schedule

Purchase

The Department has reduced its fees for most codes on the Durable Medical Equipment (DME) and Orthotic and Prosthetic Devices (O&P) fee schedules and some codes on the Medical Surgical Supplies (MSS) fee schedule by 5%.



Repairs

Repairs to most of these codes have been re-priced at 60% of the purchase price. Providers are required to bill repairs at 60% of the purchase price or MSRP minus 15%, whichever is lower.



Capped Repair Codes

Repairs or modifications greater than the allowed amounts found on the DME fee schedule for procedure codes E1220, E1399, E2291 through E2294 and K0108 will require prior authorization. Please review the fee schedules carefully for these changes.

Quantity Limitations

Diabetic and orthopedic shoes will be limited to two pairs per calendar year for members 21 years of age and over. A prior authorization (PA) request will be required for any additional pairs. Claims submitted within the calendar year for additional pairs which have not been approved with PA will be denied. The Medical Guideline regarding diabetic and orthopedic shoes can be found on the HUSKY Health website:

www.huskyhealth.com. Click on "Providers" and then click on "Policies and Procedures." Please note that orthopedic shoes are not a covered benefit for Charter Oak or HUSKY B members. Providers will need to call the HP provider assistance center to inquire about diabetic and orthopedic shoe claim history for members 21 and over. In the near future, the Department will make available a claim history inquiry feature on the Web portal so that providers can check if a member already met the benefit limit of 2 pairs of diabetic or orthopedic shoes within the calendar year, including claims paid to any of the Connecticut Medical Assistance Program (CMAP) DME providers. This feature will be available at www.ctdssmap.com. An Important Message will be posted informing when this feature is available.

Billing Diabetic Supplies

Quantities for diabetic test strips billed using procedure code A4253 (blood glucose test or reagent strips for home blood glucose monitor per 50 strips) must be billed accurately based on the HCPCS description or claims will be recouped when audited. If a member requires 200 test strips a month, the quantity to be billed should be 4 units as the description of this procedure code is "Blood glucose test strip...per 50 strips". Do not bill 200 units. Similarly, lancets which are billed using procedure code A4259 (lancets per box of 100) should be billed accurately based on the HCPCS description. If a member requires 200 lancets a month, the quantity to be billed should be 2 units. Do not bill 200 units as additional quantities will be recouped when audited.

Please be sure to note the unit value of all codes as defined by the HCPCS.

Eligibility for Breast Pumps

Breast pumps are covered under the DME benefit with a prescription from a medical provider under the mother's Medicaid identification number. Breast pumps are not covered for any non-Medicaid eligible mother and cannot be covered under the baby's Medicaid identification number. These non-eligible mothers should be referred to the Women, Infants and