

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

Physician and Independent Radiology Fee Schedule Updates and Electronic Consults for Specialists (SPA 17-V)

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 July 1, 2017, SPA 17-V will amend Attachment 4.19-B of the Medicaid State Plan by updating the fee schedules specified below in the manner described below.

First, this SPA will add Healthcare Common Procedure Coding System (HCPCS) code G0297-low dose CT scan for lung cancer to the physician radiology and independent radiology fee schedules. This code will be priced at \$162.72 for the global fee, \$131.42 for the technical component and \$31.29 for the professional component.

Second, this SPA will revise the pricing for HCPCS code J7301-Levonogestrel-releasing intrauterine contraceptive system, 13.5 mg (which is a code for Skyla, a long-acting reversible contraceptive [LARC] option) on the physician office and outpatient fee schedule. This code will be priced at \$714.70.

Third, this SPA will adjust the rates for mammography services billed under CPT codes 77065-77067 to reimburse at the same rate as the comparable mammography codes G0202-G0206. This change ensures that mammography services have a uniform pricing methodology.

Fourth, this SPA will add the following procedure codes that will be active as of July 1, 2017 and serve to replace existing procedure codes on the physician office and outpatient fee schedule. The reimbursement methodology and rates will remain the same as currently reimbursed under the current applicable procedure code.

Current Code	Replacement Code	Rate
*J3490 unclassified biologics	- Q9984 – Kyleena	\$858.33

J1725 – injection, hydroxyprogesterone caprate, 1 mg	Q9985 – Inj, hydroxyprogesterone, NOS	Manually priced based on the NDC
	Q9986 – Inj, Makena	Manually priced based on the NDC

* Please note that J3490 will continue to be a valid procedure code for billing other drugs that currently do not have a specific procedure code and are covered under current CT Medicaid policy.

Finally, this SPA will add the electronic specialist consultation codes specified below to the physician office and outpatient fee schedule. These codes pay specialist providers who bill using the physician fee schedule for providing a consultation to a primary care provider. The purpose of these electronic consultations (e-consults) is to give Medicaid members broader, more efficient, and faster access to clinical advice from specialist providers. These e-consults must be requested by a primary care provider (primary care physician, advanced practice registered nurse, or physician assistant) and may be provided by any of the following categories of specialist providers: Geriatric Nurse Practitioner, Pain Medicine, Medical Genetics, Cardiology, Dermatology, Gastroenterology, General Surgery, Geriatric Medicine, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Endocrinology, Hematology, Infectious Diseases, Rheumatology, Developmental-Behavioral Pediatrics, Pediatric Neurodevelopmental Disabilities, Pediatric Cardiology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Nephrology, Pediatric Rheumatology, Pediatric Orthopedic Surgery, Neurology-Special Qualification in Child Neurology, or Pediatric Surgery.

Specifically, this SPA will add the following Common Procedural Terminology (CPT) codes to the physician and outpatient fee schedule to reimburse for e-consults as described above.

CPT Code	Description	Rate
99446	Interprofessional telephone/internet assessment, 5-10 mins	\$13.42
99447	Interprofessional telephone/internet assessment, 11-20 mins	\$21.47
99448	Interprofessional	\$32.50

	telephone/internet assessment, 21-30 mins	
99449	Interprofessional telephone/internet assessment, 31+ mins	\$43.80

Fiscal Information

DSS estimates that the fee schedule update portions of this SPA (first three changes described above) will increase annual aggregate expenditures by approximately \$64,000 in State Fiscal Year (SFY) 2018 and \$72,000 in SFY 2019. DSS estimates that the e-consults portion of this SPA will increase annual aggregate expenditures by approximately \$396,000 in SFY 2018 and \$445,000 in SFY 2019.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS web site at this link: <http://www.ct.gov/dss>. Go to “Publications” and then “Updates”. The proposed SPA may also be obtained at any DSS field office or 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: ginny.mahoney@ct.gov or write to: Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5145, Fax: 860-424-5799). Please reference “SPA 17-V: Physician and Independent Radiology Fee Schedule Updates”.

Anyone may send DSS written comments about this SPA. Written comments must be received at the above contact information no later than July 12, 2017.

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(5) Physician's services – fixed fee schedule not to exceed the Medicare physician fee schedule. Fees may be deleted or added and priced in order to remain compliant with HIPAA or to correct pricing errors. The current fee schedule was set as of July 1, 2017 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. 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,

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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 January 1, 2017. The Department reviews Medicare rate changes annually. Any Medicaid fee that exceeds the applicable Medicare fee is reduced to 70% of the Medicare fee or the Medicare floor whichever is higher.
- X-ray services provided by independent radiology centers were set as of July 1, 2017. Select the “Independent Radiology” fee schedule, which displays global fees, including both the technical and professional components of each fee.

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