PROVIDER POLICIES & PROCEDURES

MISCELLANEOUS CODES AND MEDICAL SUPPLIES

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for miscellaneous codes and medical supplies. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Healthcare Common Procedure Coding System (HCPCS) are billing codes developed by the Centers of Medicare and Medicaid Services (CMS).They are assigned to many medical goods and services typically provided to patients (e.g., medical supplies, medical and diagnostic procedures). Some items may not have a specific HCPCS code that adequately or fully describes what is being provided. In these instances, miscellaneous codes may be appropriate until a more specific code is established.

Miscellaneous codes may be used for items that have more specific medical criteria (i.e., InterQual criteria, medical policy). If specific criteria for a particular item exists, the criteria or policy for the specific item will be used when conducting a prior authorization/medical necessity review. This policy will be used for medical supplies submitted using a miscellaneous code for which no InterQual criteria or medical policy currently exist.

Additionally, there are miscellaneous medical supplies, described by a listed HCPCS code, that are not addressed in another medical policy or criteria set. This policy will also be used for medical supplies, submitted with a listed code, for which no InterQual criteria or medical policy currently exist.

Benefit and Prior Authorization Requirements:

- Prior authorization is required for many miscellaneous HCPCS codes and supplies.
- Please refer to the DSS Fee Schedules for miscellaneous HCPCS codes and supplies requiring prior authorization.
- The Connecticut Department of Social Services (DSS) publishes a maximum quantity for each item listed on the DSS Provider Fee Schedule for MEDS-Medical/Surgical Supplies. The needs for most individuals will not exceed the fee schedule maximum. However, in some instances, individuals may require additional supplies. Please refer to the Overages for Medical Supplies policy for additional details.

CLINICAL GUIDELINE

Coverage guidelines for miscellaneous codes and supplies are made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as

follows:

Miscellaneous codes and supplies may be considered medically necessary when:

A. There is documentation from the treating physician, advanced practice registered nurse (APRN), or physician assistant (PA) dated within the past 12 months supporting the medical necessity of the requested item(s);
B. There is a signed prescription for the items (including quantity requested), written within the past 12 months from the treating physician, advanced practice registered nurse (APRN), or physician assistant (PA);
C. The item is intended for outpatient use primarily in a home setting;
D. The item is used for a medical purpose and is not useful to an individual in the absence of illness or injury;
E. For medical supplies that are used with covered DME, the supply is necessary for the effective use of the item/device; and
F. For miscellaneous codes only, there is no other listed code or combination of codes that adequately describe the item provided and the miscellaneous HCPCS code is listed on the DSS Medical/Surgical Supplies Fee Schedule.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization for many miscellaneous codes and supplies is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for medical equipment, devices, and supplies (MEDS). Coverage determinations are based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for miscellaneous codes and supplies:

- Fully completed authorization request via on-line web portal or fully completed Outpatient Prior Authorization Request form.
- A signed prescription, written within the past 12 months, from the treating physician, advanced practice registered nurse (APRN), or physician assistant (PA) enrolled in the Connecticut Medical Assistance Program (CMAP).
- A full description of the device/supply/item, manufacturer, and product number.
- Clinical documentation supporting medical necessity (nature, extent, and need for item) as outlined in the *Clinical Guideline* section of this policy.
- Pricing information as outlined in the DSS Pricing Policy for MEDS Items.

EFFECTIVE DATE

This policy for the prior authorization for miscellaneous codes and supplies for individuals covered under

the HUSKY Health Program is effective February 1, 2025.

LIMITATIONS
N/A

CODES

Miscellaneous Codes

Code	Description
A4421	Ostomy supply; miscellaneous
A4649	Surgical supply; miscellaneous
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
A9999	Miscellaneous DME supply or accessory, not otherwise specified

Miscellaneous Supplies

Code	Description
A4223	Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately)
A4457	Enema tube, with or without adapter, any type, replacement only, each
A4468	Exsufflation belt, includes all supplies and accessories
A4564	Pessary, disposable, any type
A7047	Oral interface, used with respiratory suction pump, each
A7048	Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each
A9283	Foot pressure off loading/supportive device, any type, each

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.

7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

REFERENCES

- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Regulations of Connecticut State Agencies: 17b-262-716, Requirements for Payment of Medical and Surgical Supplies – Supplies Covered and Limitations

PUBLICATION HISTORY

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