ARKANSAS REGISTER

Proposed Rule Cover Sheet

Secretary of State
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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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Name of Rule Prosthetics Rate Review - State Plan Amendment (SPA) and Prosthetics Provider Manual

Newspaper Name Arkansas Democrat Gazette

Date of Publishing September 25, 2022

Final Date for Public Comment October 24, 2022

Location and Time of Public Meeting Oct 5, 2022 11:00 AM; https://us02web.zoom.us/j/83275836656

Please provide their position (for or against) if known. Unknown

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Human Services

DIVISION Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** _____ **EMAIL:** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Prosthetics Rate Review – State Plan Amendment (SPA) and Prosthetics Provider Manual

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   _____

   (b) The reason for adoption of the more costly rule;

   _____

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   _____

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

   _____

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	_____	General Revenue	_____
Federal Funds	_____	Federal Funds	_____
Cash Funds	_____	Cash Funds	_____
Special Revenue	_____	Special Revenue	_____

Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$350,493	General Revenue	$700,986
Federal Funds	$884,507	Federal Funds	$1,769,014
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$1,235,000	Total	$2,470,000

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$

Next Fiscal Year
$

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6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ 350,493

Next Fiscal Year
$ 700,986

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

The purpose of the revisions to the Prosthetics Provider Manual and the State Plan Amendment (SPA) is to improve alignment of Prosthetic/Orthotic supplies with current Medicare codes and rates for reimbursement. The changes will allow an update of rates and align with Medicare codes to assist and improve Medicare crossover billing.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute**;**

Current procedure code and rate review were requested by the Division of Medical Services (DMS). The review reflected outdated procedure codes and rates for reimbursement. The purpose of the revisions to the Prosthetics Provider Manual and the State Plan Amendment (SPA) is to improve alignment of Prosthetic/Orthotic supplies with current Medicare codes and rates for reimbursement.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

Current procedure code and rate review were requested by the Division of Medical Services (DMS). The review reflected outdated procedure codes and rates for reimbursement. The purpose of the revisions to the Prosthetics Provider Manual and the State Plan Amendment (SPA) is to improve alignment of Prosthetic/Orthotic supplies with current Medicare codes and rates for reimbursement. Medicaid will reimburse ninety (90) percent of the current Arkansas Medicare non-rural rate. A rural rate will not be applied. Codes that do not have a Medicare comparable code or rate will be reimbursed at eighty (80) percent of the Arkansas Blue Cross/Blue Shield (BCBS) rate unless manual pricing is otherwise documented using the provider invoice. The changes will allow an update of rates and align with Medicare codes to assist and improve Medicare crossover billing.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

There are no less costly alternatives.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

Statement of Necessity and Rule Summary
Prosthetics Rate Review-State Plan Amendment and Prosthetics Provider Manual (SPA)

Why is this change necessary? Please provide the circumstances that necessitate the change.

Current procedure code and rate review were requested by the Division of Medical Services (DMS). The review reflected outdated procedure codes and rates for reimbursement. The purpose of the revisions to the Prosthetics Provider Manual and the State Plan Amendment (SPA) is to improve alignment of Prosthetic and Orthotic supplies with current Medicare codes and rates for reimbursement, and to update the SPA to align with provider manuals.". Medicaid will reimburse ninety percent (90%) of the current Arkansas Medicare non-rural rate. A rural rate will not be applied. Codes that do not have a Medicare comparable code or rate will be reimbursed at eighty percent (80%) of the Arkansas Blue Cross/Blue Shield (BCBS) rate unless manual pricing is otherwise documented using the provider invoice. The changes will allow an update of rates and align with Medicare codes to improve Medicare crossover billing.

What is the change? Please provide a summary of the change.

The State Plan Amendment (SPA) revisions are:

- Attachment 3.1-A Page 3c -For Specialized Wheelchairs provided to eligible recipients replaced "of all ages" with "two (2) years of age and older";
- Attachment 3.1-A Page 5c:
    - (5) – Added "Services for recipients who are under twenty-one (21) years of age do not require prior authorization" for orthotic appliances;
        - Replaced "age" with "years of age"; and
        - Added "…in the Procedure Code Table Link in Section II …";
    - (6) – Added "Services for recipients who are under twenty-one (21) years of age do not require prior authorization" for prosthetic devices;
        - Replaced "age" with "years of age";
        - Replaced "twenty thousand dollars ($20,000)" with "sixty thousand dollars ($60,000)";
        - Added "…in the Procedure Code Table Link in Section II …"; and
        - Added a hyper link to the Procedure Code Table in Section II;
- Attachment 3.1-B Page 3e - For Specialized Wheelchairs provided to eligible recipients replaced "of all ages", with "two (2) years of age and older";
- Attachment 3.1-B Page 5b:
    - (5) - Added "Services for recipients who are under twenty-one (21) years of age do not require prior authorization" for orthotic appliances;
        - Replaced "age" with "years of age";
        - Added "…in the Procedure Code Table Link in Section II …";
    - (6) - Added "Services for recipients who are under twenty-one (21) years of age do not require prior authorization" for prosthetic devices;
        - Replaced "age" with "years of age";
        - Replaced "twenty thousand dollars ($20,000)" with "sixty thousand dollars ($60,000)";
        - Added "…in the Procedure Code Table Link in Section II …"; and
        - Added a hyper link to the Procedure Code Table in Section II;
- Attachment 4.19-B Page 4c:
    - Added "Effective for dates of service on or after January 1, 2023, reimbursement rate maximums for orthotic appliances and prosthetic devices will be set at ninety percent (90%)

of the January 1, 2022, Medicare non-rural rate for the State of Arkansas. For orthotic and prosthetic codes not listed on the Medicare fee schedule, reimbursement rate maximums for dates of service on or after January 1, 2023, will be set at eighty percent (80%) of the January 1, 2022, Arkansas Blue Cross/Blue Shield rate, or manually priced";
    - Added a hyper link to the Medicaid Fee Schedules provider list; and
- Prosthetics Provider Manual
    - Updated Table of Contents – 212.212 and 212.213.
    - Section 212.212 Replaced "All ages" with "two (2) years of age and older"; and
    - Section 212.213 Replaced "Age two (2) through adulthood" with "two (2) years of age and older".
- Updated stylistic formatting of age and numerical references throughout all pages.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services (DMS) of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129.

Effective January 1, 2023:

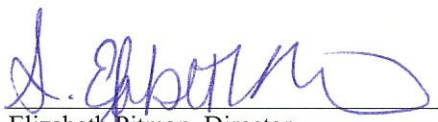
The Division of Medical Services revises the Prosthetics Provider Manual and the State Plan Amendment (SPA) to improve alignment of Prosthetic and Orthotic supplies with current Medicare codes and rates for reimbursement. The division also updates the SPA to align with provider manuals. Clarifies age ranges eligible for services in both the SPA and the Prosthetics Provider Manual. Medicaid will reimburse ninety percent (90%) percent of the current Medicare Arkansas non-rural rate. A rural rate will not be applied. Codes, that do not have an equivalent Medicare comparable code or rate, will be reimbursed at eighty percent (80%) percent of the Arkansas Blue Cross/Blue Shield (BCBS) rate unless manual pricing is otherwise documented using the provider invoice. The changes will allow an update of rates and align with Medicare codes to improve Medicare crossover billing. The projected annual cost of this change for state fiscal year (SFY) 2022 is $1,235,000 and for SFY 2023 is $2,470,000.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than October 24, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on October 5, 2022, at 11:30 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/83275836656. The webinar ID is 832 7583 6656. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. 4502100209



Elizabeth Pitman, Director
Division of Medical Services

SECTION II - PROSTHETICS
CONTENTS

212.213 (DME) Specialized Wheelchairs and Wheelchair Seating Systems for Individuals ~~Age Two Through Adult~~ Two (2) Years of Age and Older

~~8-1-21~~ 1-1-23

Arkansas Medicaid covers specialized wheelchairs and wheelchair seating systems for individuals ~~age two (2) through adulthood~~ two (2) years of age and older.

Some items of specialized equipment require prior authorization from DHS or its designated vendor. **View or print form DMS-679 and instructions for completion.** **View or print contact information for how to submit the request**.

CATEGORICALLY NEEDY

7.a.~~-~~ Home Health Services

7.b. Based on a physician's prescription as to the medical necessity provided to eligible recipients at their place of residence, not to include institutions required to provide these services, for services above fifty (50) visits per recipient per State Fiscal Year, the provider must request an extension. Extension of the benefit limit will be provided for all recipients, including EPSDT, if determined medically necessary.

7.c. Medical supplies, equipment, and appliances suitable for use in the home

(1) Medical supplies are covered for eligible Medicaid recipients when determined medically necessary and prescribed by a physician. Services are provided in the recipient's home. (Home does not include a long-term care facility.) Supplies are limited to a maximum reimbursement of two hundred fifty dollars ($250)~~.00~~ per month, per recipient. As medical supplies are provided to recipients through the Home Health Program and the Prosthetics Program, the maximum reimbursement of two hundred fifty dollars ($250)~~.00~~ per month may be provided through either program, or a combination of the two (2). However, a recipient may not receive more than two hundred fifty dollars ($250)~~.00~~ in supplies, whether received through either of the programs or a combination of the two (2), unless an extension has been granted. Extensions will be considered for recipients who are under~~r age~~ twenty-one (21) years of age in the Child Health Services (EPSDT) Program if documentation verifies medical necessity. The provider must request an extension of the established benefit limit.

(2) Durable Medical Equipment (DME) - Services are covered in the recipient's home if prescribed by the recipient's physician as medically necessary. Some DME requires prior authorization. DME is limited to specific items. Specific DME is listed in Section III of the Prosthetics Provider Manual.

(3) Augmentative Communication Device

Services for recipients who are under twenty-one~~age~~ (21) years of age are covered as a result of a Child Health Services (EPSDT) screening and ~~/~~referral. Services for recipients who are twenty-one (21) years of age and~~or~~ over~~over age 21~~ are covered if prescribed by the recipient's physician as medically necessary. Prior authorization is required.

(4) Specialized Wheelchairs

Specialized Wheelchairs are provided for eligible recipients who are ~~of all ages~~ two (2) years of age and older~~through adult~~ if prescribed by the recipient's physician as medically necessary. Prior authorization is required for some items. These items are listed in Section III of the Prosthetics Provider Manual.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye, or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

(5) Orthotic Appliances

Services for recipients who are under twenty-one (21) years of age~~under age 21~~ are not benefit limited.
Services for recipients who are under twenty-one (21) years of age~~under age 21~~ do not require prior authorization.

Services for recipients who are twenty-one (~~age~~ 21) years of age and over are limited to three thousand dollars ($3,000) ~~-~~per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for an orthotic appliance is five hundred dollars ($500) or more, prior authorization is required. Specific covered orthotic appliances are listed in the Procedure Code Table link in Section II~~I~~ of the Prosthetics Provider Manual.

(6) Prosthetic Devices

Services for recipients who are under twenty-one (21) years of age~~under age 21~~ are not benefit limited.
Services for recipients who are under twenty-one (21) years of age~~under age 21~~ do not require prior authorization.

Services for recipients ~~age~~ who are twenty-one (21) years of age and over are limited to ~~$20,000~~ sixty thousand dollars ($60,000) per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for a prosthetic device is one thousand dollars ($1,000) or more, prior authorization is required. Specific covered prosthetic devices are listed in the Procedure Code Table link in Section II~~I~~ of the Prosthetics Provider Manual. View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures, and services.

7.a. Home Health Services

7.b. Based on a physician's prescription as to medical necessity provided to eligible recipients at their place of residence, not to include institutions required to provide these services. For services above fifty (50) visits per recipient per State Fiscal Year, the provider must request an extension. Extension of the benefit limit will be provided for all recipients, including EPSDT, if determined medically necessary.

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

(1) Medical supplies are covered for eligible Medicaid recipients when determined medically necessary and prescribed by a physician. Services are provided in the recipient's home. (Home does not include a long-term care facility.) Supplies are limited to a maximum reimbursement of two hundred fifty dollars ($250).00 per month, per recipient. As medical supplies are provided to recipients through the Home Health Program and the Prosthetics Program, the maximum reimbursement of two hundred fifty dollars ($250).00 per month may be provided through either program or a combination of the two (2). However, a recipient may not receive more than two hundred fifty dollars ($250).00 in supplies, whether received through either of the two programs or a combination of the two (2), unless an extension has been granted. Extensions will be considered for recipients who are under twenty-one (21) years of age and 21 in the Child Health Services (EPSDT) Program, if documentation verifies medical necessity. The provider must request an extension of the established benefit limit.

(2) Durable Medical Equipment (DME) - Services are covered in the recipient's home if prescribed by the recipient's physician as medically necessary. Some DME requires prior authorization. DME is limited to specific items. Specific DME is listed in Section III of the Prosthetics Provider Manual.

(3) Augmentative Communication Device

Services for recipients who are under twenty-one (21) years of age 21 are covered as a result of a Child Health Services (EPSDT) screening and referral. Services for recipients who are over twenty-one (21) years of age and or over 21 are covered if prescribed by the recipient's physician as medically necessary. Prior authorization is required.

(4) Specialized Wheelchairs

Specialized Wheelchairs are provided for eligible recipients who are of all ages two (2) years of age and older through adult if prescribed by the recipient's physician as medically necessary. Prior authorization is required for some items. These items are listed in Section III of the Prosthetics Provider Manual.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye, or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

(5) Orthotic Appliances

Services for recipients who are under twenty-one (21) years of age ~~21~~ are not benefit limited.
Services for recipients who are under twenty-one (21) years of age ~~age 21~~ do not require prior authorization.

Services for recipients ~~age~~ who are twenty-one (21) years of age and over are limited to three thousand dollars ($3,000) per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for an orthotic appliance is five hundred dollars ($500) or more, prior authorization is required. Specific covered orthotic appliances are listed in the Procedure Code Table link in Section II~~I~~ of the Prosthetics Provider Manual.

(6) Prosthetic Devices

Services for recipients who are under twenty-one (21) years of age~~under~~ ~~age 21~~ are not benefit limited.
Services for recipients who are under twenty-one (21) years of age~~under age 21~~ do not require prior authorization.

Services for recipients ~~age~~ who are twenty-one (21) years of age and over are limited to ~~$20,000~~ sixty thousand dollars ($60,000) per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for a prosthetic device is one thousand dollars ($1,000) or more, prior authorization is required. Specific covered prosthetic devices are listed in the Procedure Code Table link in Section II~~I~~ of the Prosthetics Provider Manual. View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures, and services.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye, or by an optometrist (Continued)

c. Prosthetic Devices (continued)

(6) Orthotic Appliances and Prosthetic Devices

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. State developed fee schedule rates are the same for both public and private providers of orthotic appliances and prosthetic devices.

Effective for dates of service occurring on and after September 1, 2006, reimbursement rate maximums for Medicaid covered orthotic appliances and prosthetic devises are based on one hundred percent (100%) of the 2006 DMEPOS Medicare rates.

For the following procedure codes not reflecting a rate on the 2006 DMEPOS Medicare fee schedule, reimbursement rate maximums for dates of service occurring September 1, 2006, and after, will be based on one hundred percent (100%) of the 2006 Arkansas Blue Cross/Blue Shield rate:

A5510 = $30.28, L0452 = $263.81, L3202 = $51.21, L3204 = $50.12, L3206 = $51.93, L3207 = $52.67, L3208 = $28.58, L3209 = $39.53, L3211 = $42.11, L3215 = $93.94, L3216 = $113.29, L3219 = $105.26, L3221 = $126.00, L3222 = $139.22, L3230 = $163.33, L3250 = $331.47, L3253 = $44.64, L3257 = $32.95, L3265 = $20.54, L3902 = $1,980.19, L4205 = $35.00, L4210 = $28.27, L7500 = $67.55, L7520 = $15.00

Effective for dates of service on or after January 1, 2023, reimbursement rate maximums for orthotic appliances and prosthetic devices will be set at ninety percent (90%) of the January 1, ~~2023~~2022 Medicare non-rural rate for the State of Arkansas. For orthotic and prosthetic codes not listed on the Medicare fee schedule, reimbursement rate maximums for dates of service on or after January 1, 2023, will be set at eighty percent (80%) of the January 1,~~2023~~ 2022, Arkansas Blue Cross/Blue Shield rate, or manually priced.

All rates are published on the agency's website Fee Schedules - Arkansas Department of Human Services **. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.**