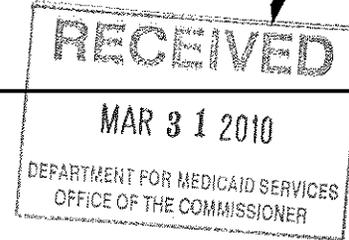


Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909



March 29, 2010

Ms. Elizabeth A. Johnson
Commissioner
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40621-0001

*To Sharley
File*

Attention: Sharley Hughes

RE: Kentucky Title XIX State Plan Amendment, Transmittal #08-016

Dear Ms. Johnson

We accept your request, dated March 25, 2010 to withdraw State Plan Amendment 08-016. We are returning the Form HCFA-179 and the proposed plan pages.

If you have any questions or need any further assistance, please contact Maria Donatto at (404) 562-3697.

Sincerely,

Jackie Glaze
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures



CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

275 E. Main Street, 6W-A
Frankfort, KY 40621
(502) 564-4321
Fax: (502) 564-0509
www.chfs.ky.gov

Janie Miller
Secretary

Elizabeth A. Johnson
Commissioner

December 31, 2008

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Dear Ms. Justis:

Kentucky Title XIX State Plan Transmittal No. 08-016.
Definition of Outpatient Hospital Services

Enclosed is a copy of the Kentucky Title XIX Transmittal Number 08-016. This plan amendment is a revision in the definition of outpatient hospital services. The definition was established in the Centers for Medicare and Medicaid Services (CMS) rule "CMS-2213-F" published on November 7, 2008 in the Federal Register or 42 CFR 440.20.

If additional information is needed, please contact my office at 502-564-4321.

Sincerely,

*Carol Muldoon, Deputy Commissioner
(on behalf of)*

Elizabeth A. Johnson
Commissioner

EJ/RD/NW/SO/ks

Enclosure

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
08-016

2. STATE
Kentucky

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 8, 2008

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.20

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 - budget neutral
b. FFY 2010 - budget neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 3.1-A page 7.1.1(a); Att. 3.1-B page 13.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

Same

10. SUBJECT OF AMENDMENT:

This plan amendment is a revision in the definition of outpatient hospital services. The definition was established in the Centers for Medicare and Medicaid Services (CMS) rule "CMS-2213-F" published on November 7, 2008 in the Federal Register.

11. GOVERNOR'S REVIEW (*Check One*):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Carol Muldoon (on behalf of...)

13. TYPED NAME: Elizabeth A. Johnson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: December 31, 2008

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

- g) Excision: barthotin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
 - h) Extraction: foreign body, and teeth (per existing policy).
 - i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
 - j) Hymenotomy.
 - k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
 - l) Meatotomy/ urethral dilation, removal calculus and drainage of bladder without incision.
 - m) Myringotomy with or without tubes, otoplasty.
 - n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, otoscopy, and sigmoidoscopy or proctosidmoidoscopy.
 - o) Removal: IUD, and fingernail or toenails.
 - p) Tenotomy hand or foot.
 - q) Vasectomy.
 - r) Z-plasty for relaxation of scar/contracture.
- d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2a. Outpatient Hospital Services

Outpatient Hospital Services is defined in 42 CFR 440.20.

To be covered by the department, the following hospital outpatient services shall be prior authorized and meet the additional requirements of the outpatient hospital services section:

- a) Computed tomographic angiography (CTA);
- b) Magnetic resonance imaging (MRI);
- c) Magnetic resonance angiogram (MRA);
- d) Magnetic resonance spectroscopy;
- e) Positron emission tomography (PET);
- f) Cineradiography/videoradiography;
- g) Xeroradiography;
- h) Ultrasound subsequent to second (2nd) obstetric ultrasound;
- i) Unlisted procedure;
- j) Myocardial imaging;
- k) Cardiac blood pool imaging;
- l) Radiopharmaceutical procedures;
- m) Gastric restrictive surgery or gastric bypass surgery;
- n) A procedure that is commonly performed for cosmetic purposes;
- o) A surgical procedure that requires completion of a federal consent form

- d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

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- m) Gastric restrictive surgery or gastric bypass surgery;
- n) A procedure that is commonly performed for cosmetic purposes;
- o) A surgical procedure that requires completion of a federal consent form

Outpatient Hospital Speech and Physical Therapy services shall be limited to those limits found in Attachment 3.1-B page 30 for Global Choices, and Attachment 3.1-C pages 10.22 and 10.23 for Comprehensive Choices and Optimum Choices. The Speech and Physical therapy limits may be over-riden if the department determines that additional visits beyond the limit are medically necessary. Except for recipients under age twenty-one (21), prior authorization is required for each visit that exceeds the Speech and Physical therapy limits established in Attachment 3.1-C page 10.18.

An outpatient hospital service not identified in the above paragraph shall be:

- a) Medically necessary; and
- b) clinically appropriate.

The above prior authorization requirements do not apply to:

- a) An emergency service;
- b) A radiology procedure if the recipient has a cancer or transplant diagnosis code; or
- c) A service provided to a recipient in an observation bed.