

July 31, 2008

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

Attention: Kevin Skeeters

RE: Kentucky Title XIX State Plan Amendment, Transmittal #07-007

Dear Mr. Crouch:

The State of Kentucky requested CMS approve the following plan amendment:

- 1) Establish coverage for risperidone and for drugs or biologicals, that which require special handling and/or must be administered in a physician's office;
- 2) Increase evaluation and management services visit from one (1) per recipient per year to two (2) per recipient per year and allows for additional visits if prior authorization is obtained;
- 3) Introduce a flat rate of \$72 per office visit conducted after standard office hours (beginning after 5:00 p.m. Monday through Friday or beginning after 12:00 p.m. on Saturday through the remainder of the weekend);
- 4) Reimburse for anesthesia services based on an actual time vs. an average amount of time;
- 5) Increase vaginal delivery related anesthesia from \$200 to \$215;
- 6) Increase Cesarean section anesthesia from \$320 to \$335;
- 7) Increase Neuroxial labor anesthesia from \$335 to \$350; and
- 8) Increase non-delivery related anesthesia dollar conversion factor from \$13.86 to \$15.20;

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 07-007 was approved on July 24, 2008. The effective date for this amendment is October 1, 2007. We are also enclosing the approved HCFA-179 and plan page.

Mr. Shaw M. Crouch

Kentucky Title XIX State Plan Amendment, Transmittal #07-007

If you have any questions or need any further assistance, please contact Maria Donatto at (404) 562-3697 or Yvette Moore at 404-562-7414.

Sincerely,

A handwritten signature in cursive script that reads "Elaine Gilmore for".

Mary Kaye Justis, RN, MBA

Acting Associate Regional Administrator

Division of Medicaid & Children's Health Operations

Enclosures

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

1. TRANSMITTAL NUMBER:
07-007

2. STATE
Kentucky

FROM: 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
October 1, 2007

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 447.10- 447.25

7. FEDERAL BUDGET IMPACT:
a. FFY 2007 - indeterminable
b. FFY 2008 - indeterminable

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A p. 7.2.1, 7.2.1(a);
Attachment 3.1-B p. 21, 22; and
Attachment 4.19-B p. 20.1(b), 20.3(a), 20.4, 20.5

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Same

10. SUBJECT OF AMENDMENT:

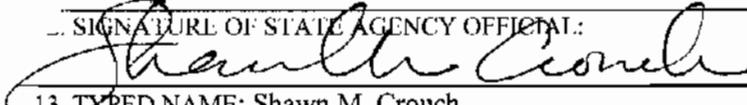
This plan amendment implements changes to physician reimbursement.

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

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

SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Shawn M. Crouch

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: November 28, 2007

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

11/27/07

18. DATE APPROVED:

07/24/08

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10/01/07

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Mary Kaye Justis, RN, MBA

22. TITLE:

Acting Associate Regional Administrator
Division of Medicaid & Children's Health Care

23. REMARKS:

Approved with the following changes as authorized by the State Agency on e-mail dated July 14, 2008: block number 7,
Block number 7a FFY 07 indeterminable changed to read FFY08 \$30,005,400 and block number 7b FFY08 indeterminable
changed to read FFY09 \$30,155,900.

5. Physicians' Services

- A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

- B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician. If this limit is exceeded, then DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.

- C. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.

- D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only, which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

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- L. A patient "locked in" to one physician due to over-utilization may receive physician services only from his/her lock-in provider except in the case of an emergency or referral.
- F. The cost of preparations used in injections is not considered a covered benefit, except for the following:
- (1) The Rhogam injection.
 - (2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
 - (3) Depo Provera provided in the physician office setting.
 - (4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
 - (5) Long acting injectable risperidone.
 - (6) An injectable, infused or inhaled drug or biological that is:
 - a. Not typically self-administered;
 - b. Not listed as a noncovered immunization or vaccine; and
 - c. Requires special handling, storage, shipping, dosing or administration.
- G. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.
- H. Telephone contact between a physician and patient is not a covered service.
- I. Coverage of a physician service is contingent upon direct physician and patient interaction except in the following cases:
- (1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
 - (2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

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New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

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New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

- B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician. If this limit is exceeded, then DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
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- E. A patient "locked in" to one physician due to over-utilization may receive physician services only from his/her lock-in provider except in the case of an emergency or referral.
- F. The cost of preparations used in injections is not considered a covered benefit, except for the following:
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 - (2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
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- H. Telephone contact between a physician and patient is not a covered service.
- I. Coverage of a physician service is contingent upon direct physician and patient interaction except in the following cases:
- (1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
 - (2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

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5. The department shall reimburse the following drugs at the lesser of the actual billed charge or average wholesale price (AWP) minus ten (10) percent if the drug is administered in a physician's office:
- a. Rho(D) immune globulin injection;
 - b. An injectable antineoplastic drug;
 - c. Medroxyprogesterone acetate for contraceptive use, 150 mg;
 - d. Penicillin G benzathine injection;
 - e. Ceftriaxone sodium injection;
 - f. Intravenous immune globulin injection;
 - g. Sodium hyaluronate or hylan G-F for intra-articular injection;
 - h. An intrauterine contraceptive device;
 - i. An implantable contraceptive device;
 - j. Long acting injectable risperidone; or
 - k. An injectable, infused or inhaled drug or biological that is:
 - (1) Not typically self-administered;
 - (2) Not listed as a noncovered immunization or vaccine; and
 - (3) Requires special handling, storage, shipping, dosing or administration.

If long acting injectable risperidone is provided to an individual covered under both Medicaid and Medicare and administered by a physician employed by a Community Mental Health Center (CMHC) or other licensed medical professional employed by a CMHC, the department shall provide reimbursement at the same rate it reimburses for these drugs provided to a Medicaid recipient, except that the department shall reduce reimbursement by the amount of the third party obligation.

(3) The flat rate for a service shall be established by multiplying the dollar conversion factor by the sum of the RVU units plus the number of units spent on that specified procedure. RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

<u>Types of Service</u>	<u>Kentucky Conversion Factor</u>
Deliveries	Not applicable
Non-delivery Related Anesthesia	\$15.20
Non-anesthesia Related Services	\$29.67

(4) The fixed upper limit for a covered anesthesia service shall not exceed the upper limit that was in effect on June 1, 2006 by more than twenty (20) percent. The reimbursement shall not decrease below the upper payment limit in effect on June 1, 2006.

C. Reimbursement Exceptions

(1) Physicians will only be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the Vaccines for Children Program to provide immunizations for Medicaid recipients under the age of nineteen (19). Vaccine costs will not be reimbursed.

(2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Delivery only	\$870.00
Vaginal delivery including postpartum care	\$900.00
Cesarean delivery only	\$870.00
Cesarean delivery including postpartum care	\$900.00

(3) For delivery-related anesthesia services provided on or after July 1, 2006, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Vaginal delivery	\$215.00
Cesarean section	\$335.00
Neuroxial labor anesthesia for a vaginal delivery or cesarean section	\$350.00
Additional anesthesia for cesarean delivery following neuroxial labor anesthesia for vaginal delivery	\$25.00
Additional anesthesia for cesarean hysterectomy following neuroxial labor anesthesia	\$25.00

(4) Payment for individuals eligible for coverage under Medicare Part B is made, in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.

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- (5) For services provided on or after July 1, 1990, family practice physicians practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the physicians' usual and customary actual billed charges up to 125 percent of the fixed upper limit per procedure established by the Department.
- (6) For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the Medicare allowable payment rates. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.
- (7) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the physician's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.
- (8) Payments for the injection procedure for chemonucleolysis of intervertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or at a fixed upper limit of \$793.50 as established by the Department.
- (9) Specified family planning procedures performed in the physician office setting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS *fee* plus actual cost of the supply minus ten percent.
- (10) Certain injectable antibiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.
- (11) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).
- (12) For a practice-related service provided by a physician assistant, the participating physician shall be reimbursed at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the Department for Medicaid Services at seventy-five (75) percent of the physician's fixed upper limit per procedure.
- (13) Any physician participating in the lock-in program will be paid a \$10.00 per month lock-in fee for provision of patient management services for each recipient locked-in to that physician.

- (14) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan to physicians that qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.
- a. To qualify for a supplemental payment under this section, physicians must meet the following criteria:
 1. Be Kentucky licensed physicians;
 2. Be enrolled as Kentucky Medicaid providers; and
 3. Be Medical School Faculty Physicians as defined in Att 4.19-B, page 20.3, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.
 - b. For physicians qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between payments otherwise made to these physicians and the average rate paid for the services by commercial insurers. The payment amounts are determined by:
 1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the providers' contracted rates with commercial insurers for each procedure code from an actual year's data, beginning with CY 2006;
 2. Multiplying the total number of Medicaid claims paid per procedure code by the average commercial payment rate for each procedure code to establish the estimated commercial payments to be made for these services; and
 3. Subtracting the initial fee-for-service Medicaid payments, all Medicare payments, and all Third Party Liability payments already made for these services to establish the supplemental payment amount. Effective January 1, 2007 all claims where Medicare is the primary provider will be excluded from the supplemental payment methodology.
 4. The supplemental payments will be calculated annually after the end of each CY using actual data from the most recent completed CY. Claims data will only be used for physicians meeting the criteria in Part (a) above. If a physician did not meet the criteria for the whole calendar year, then only the claims data that coincides with their dates of eligibility will be used in the calculation. The supplemental payments will not be increased with any trending or inflationary indexes.
 - c. Initial fee-for-service payments under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made as four (4) equal quarterly payments.
- (15) A second anesthesia service provided by a provider to a recipient on the same date of service shall be reimbursed at the Medicaid Physician Fee Schedule amount established by the Department.
- (16) A bilateral procedure shall be reimbursed at one hundred fifty (150) percent of the amount established by the Department.
- (17) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) or over age seventy (70).
- (18) Physicians will only be reimbursed for the administration of immunizations, to include the influenza vaccine, to a Medicaid recipient of any age. Vaccine costs will not be reimbursed.
- (19) The department shall reimburse a flat rate of seventy-two (72) dollars per office visit for an office visit beginning after 5:00pm Monday through Friday or beginning after 12:00pm on Saturday through the remainder of the weekend.
- (20) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of \$150.
- (21) For an evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit outlined in Att 3.1-A, p. 7.2.1 & Att 3.1-B, p. 21, DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- (22) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 have been enhanced from approximately fifty-seven (57) percent of Medicare allowable to eighty-seven and one half (87.5) percent of Medicare allowable.
- D. Assurances. The State hereby assures that payment for physician services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.