
June 17, 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 #06-013

Dear Ms. Johnson:

We have reviewed the proposed amendment to the Kentucky Medicaid State Plan that was submitted under transmittal number 06-013. This amendment requests approval to revise the non-anesthesia related services and the reimbursement for anesthesia services. The revisions include payment for second anesthesia services delivered by a provider to a recipient on the same date of service; a fixed rate of \$25.00 for anesthesia add-on services provided to a recipient under age one (1) or over age seventy (70); a bilateral procedure shall be reimbursed at 150 percent of the amount established by the Department and when medically necessary limits are soft limits subject to prior authorization.

Under regulations at 42 CFR 430.12 (c)(i), States are required to amend State Plans whenever necessary to implement changes in Federal law, regulations, policy interpretations, or court decisions. On May 25, 2007, CMS placed a final rule, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) on display at the Federal Register that can be found at 72 Fed. Reg. 29748 (May 29, 2007), that would modify Medicaid reimbursement. Because of this regulation, some or all of the payments under this plan amendment may no longer be allowable expenditures for Federal Medicaid matching funds. Public Law 110-28, enacted on May 25, 2007, instructed CMS to take no action to implement this final regulation for one year. CMS will abide by the time frames specified by the statute. Approval of the subject State Plan amendment does not relieve the State of its responsibility to comply with changes in Federal laws and regulations and to ensure that claims for Federal funding are consistent with all applicable requirements.

Ms. Elizabeth A. Johnson
Kentucky Title XIX State Plan Amendment, Transmittal #06-013

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 06-013 was approved on June 12, 2008. The effective date for this amendment is July 1, 2006. We are also enclosing the approved HCFA-179 and plan page.

If you have any questions or need any further assistance, please contact Maria Donatto at 404-562-3697 or Yvette Moore at (404) 562-7327.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. DeCaro', written in a cursive style.

Teresa DeCaro, RN, M.S.
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 06-013	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE July 1, 2006	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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)

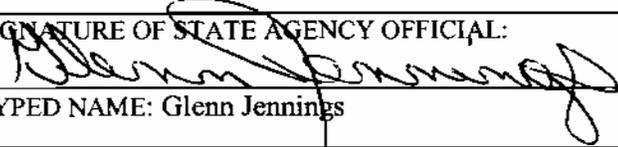
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.10-447.25	7. FEDERAL BUDGET IMPACT: a. FFY 2006 Budget Neutral b. FFY 2007 Budget Neutral
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 3.1-A Pages 7.2.1(a)(o), 13; Att. 3.1-B Pages 22.1(a), 39; and Att. 4.19-B Pages 20.3, 20.3a, 20.4, 20.5	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same

10. SUBJECT OF AMENDMENT:

This plan amendment contains changes to non-anesthesia and anesthesia physician reimbursement.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Review delegated
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED to Commissioner, Department for Medicaid
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Services

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Glenn Jennings	
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: 9/29/06	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/29/06	18. DATE APPROVED: 06/12/08
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/06	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Teresa DeCaro	22. TITLE: Acting Associate Regional Administrator Division of Medicaid & Children's Health Opps

23. REMARKS:

Approved with the following changes as authorized by the State Medicaid Agency RAI letter dated 5-30-08: block # 7a FFY 2006 Budget Neutral should read FFY 2006 \$118,000 and 7b FFY 2007 Budget Neutral should read FFY 07 \$471,652.

- J. 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.
- K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.
- L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.
- M. Epidural or spinal injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.
- N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
MEDICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; and shall be medically necessary and reasonable.

- a. A provider must be Medicare and Medicaid certified. Items must be medically necessary and, if required, prior authorized.
- b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.
- c. Any item designated by a covered HCPCS code being reimbursed at \$150.00 or more will require prior authorization.
- d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.
- e. The following general types of durable medical equipment, medical supply, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:
 1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
 2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
 3. Physical fitness equipment, such as exercycles and treadmills;
 4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
 5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
 6. Items considered educational or recreational.
- f. A cast or splint shall be limited to two (2) per ninety (90) day period for the same injury or condition.

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II. Physician Services

A. Definitions

(1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.

(2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.

(3) "Medical School Faculty Physician" is a physician who is employed by a state-supported school of medicine (for teaching and clinical responsibilities), receives their earnings statement (W-2) from the state-supported school of medicine for their teaching and clinical responsibilities, and they are part of a university health care system that includes:

- (a) a teaching hospital; and
- (b) a state-owned pediatric teaching hospital; or
- (c) an affiliation agreement with a pediatric teaching hospital.

(4) Reimbursement for an anesthesia service shall include:

- (a) Preoperative and postoperative visits;
- (b) Administration of the anesthetic;
- (c) Administration of fluids and blood incidental to the anesthesia or surgery;
- (d) Postoperative pain management;
- (e) Preoperative, intraoperative, and postoperative monitoring services; and
- (f) Insertion of arterial and venous catheters.

B. Reimbursement

- (1) Payment for covered physicians' services shall be based on the physicians' usual and customary actual billed charges up to the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS).
- (2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit by reimbursing 45% of billed charges. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

(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 minutes. 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	\$13.86
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	\$200.00
Cesarean section	\$320.00
Neuroxial labor anesthesia for a vaginal delivery or cesarean section	\$335.00
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.

(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 (h) 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.
- 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.