CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

275 E. Main Street, 6W-A
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Janie Miller
Secretary

Neville Wise
Acting Commissioner

July 8, 2011

Jackie Glaze
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

RE: Kentucky State Plan Amendment 11-006

Dear Ms. Glaze:

Enclosed please find Kentucky Title XIX Transmittal Number 11-006. This State Plan Amendment is being submitted as a result of the Companion Letter issued on May 12, 2011 with SPA 11-003. DMS has included a copy of this letter for your reference. The page corrections outlined in Question #1a through #1h have all been addressed and attached, as well as Question #3 and #4. In regards to question #2, DMS confirms that the Non-anesthesia Related Services Conversion Factor of $29.67 does apply to all physician services. The submission of this State Plan Amendment brings Kentucky in compliance with all issues outlined in the Companion Letter.

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

Sincerely,

Neville Wise
Acting Commissioner

NW/sjh

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-006

2. STATE: Kentucky

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
07/01/2011

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(30)(A)

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 - Budget Neutral
b. FFY 2012 - Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 4.19-B, Page 20.9
Page 4.19-B, Page 20.9(a)
Page 4.19-B, Page 20.43
Att. 4.19-B, Page 20.3
Att. 4.19-B, Page 20.4

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

SAME

10. SUBJECT OF AMENDMENT
The purpose of this SPA is to remove the phrases "up to" and "not to exceed" from section 4.19-B as outlined in the Companion Letter issued with SPA 11-003 approval.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Neville Z Wise

13. TYPED NAME: Neville Wise

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: March 23, 2011

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:

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

May 12, 2011

Neville Wise, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40621-0001

Attention: Sharley Hughes

Re: Kentucky Title XIX State Plan Amendment, KY 11-003

Dear Mr. Wise:

This letter is being sent as a companion to our approval of Kentucky State Plan Amendment (SPA) KY 11-003 that was submitted to provide clarification regarding the coverage of optometrists under the Kentucky Medicaid Program. During our review of KY 11-003, we noted that KY' State Plan reimbursement pages (Attachment 4.19-B, pages 20.3, 20.3(a), 20.4, 20.9, 20.9(a), and 20.43) do not meet comprehensiveness requirements. Based on that review, it was determined that these pages are not consistent with the Medicaid statutory and regulatory requirements described below. While we are proceeding with the approval of Kentucky SPA 11-003, this letter follows up on these matters as we want to work with you to resolve these issues.

Statutory and Regulatory Requirements

Section 1902(a) of the Social Security Act (the Act) requires that States have a State plan for medical assistance that meets certain federal requirements that set out a framework for the State program.

Section 1902(a)(30)(A) of the Act requires that States have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy, and quality of care. To be comprehensive, payment methodologies should be understandable, clear, and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

42 CFR 430.10 requires that the State plan be a comprehensive written statement that describes the nature and scope of the State's Medicaid program and that it contain all information necessary for CMS to determine whether the plan can be approved to serve as the basis for Federal financial participation (FFP) in the State program.

State Plan Comprehensiveness:

1. Use of the phrases "up to" and "not to exceed" are not comprehensive since it appears as if providers will be paid some amount between their charges and another amount (i.e., the fixed upper limit per procedure, upper limit for materials or Medicare allowable reimbursement rates) with no way to identify the rate ultimately paid to providers. In order to meet comprehensiveness, please omit the use of language that gives the appearance of a rate range on the following pages.

a. Attachment 4.19-B, page 20.3, paragraph B.(1). This paragraph currently reads: "...shall be based on the physicians' usual and customary actual billed charges **up to** the fixed upper limit per procedure..." This section could be rewritten to read: "...shall be based on the lesser of the physicians' usual and customary actual billed charges or the fixed upper limit per procedure..."

b. Attachment 4.19-B, page 20.4, paragraph C.(5). This paragraph currently reads: "...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." This section could be rewritten to read: "...shall be reimbursed at the lesser of the physicians' usual and customary actual billed charges or 125% of the fixed upper limit per procedure established by the Department."

c. Attachment 4.19-B, page 20.4, paragraph C.(12). This paragraph currently reads: "...shall be reimbursed at the usual and customary actual billed charges **up to** the fixed upper limit per procedure established by the Department..." This section could be rewritten to read: "...shall be reimbursed at the lesser of the usual and customary actual billed charge or the fixed upper limit per procedure established by the Department..."

d. Attachment 4.19-B, page 20.9, paragraph IV.B.(1). The first paragraph currently reads: "...shall be based on the optometrists' usual and customary actual billed charges **up to** the fixed upper limit per procedure..." This section could be rewritten to read: "shall be based on the lesser of the optometrists' usual and customary actual billed charges or the fixed upper limit per procedure..."

e. Attachment 4.19-B, page 20.9, paragraph IV.B.(4). The first sentence currently reads: "Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made at the optical laboratory cost of the materials **not to exceed** upper limits for materials as set by the Department." This section could be rewritten to read "Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made at the lesser of the optical laboratory costs of the materials or the upper limits for materials as set by the Department."

f. Attachment 4.19-B, page 20.9(a), paragraph (5). The first sentence currently reads: "Laboratory services shall be reimbursed at the actual billed amount **not to exceed** Medicare allowable reimbursement rates." This section could be rewritten to read: "Laboratory services shall be reimbursed at the lesser of the actual billed amount or Medicare allowable reimbursement rates."

g. Attachment 4.19-B, page 20.43, paragraph B.(1). The first sentence currently reads: "Payment for covered chiropractors' services shall be based on the chiropractors' usual and customary actual billed charges **up to** the fixed upper limit per procedure..." This section could be rewritten to read: "Payment for covered chiropractors' services shall be based on the lesser of the chiropractors' usual and customary actual billed charges or the fixed upper limit per procedure..."

h. Attachment 4.19-B, page 20.43, paragraph B.(2)(2). This paragraph reads: "...shall be reimbursed at the chiropractors' usual and customary actual billed charges **up to** 125 percent of the fixed upper limit per procedure..." This section could be rewritten to read: "...shall be reimbursed at the lesser of the chiropractors' usual and customary actual billed charges or 125 percent of the fixed upper limit per procedure..."

2. Attachment 4.19-B, page 20.3(a), paragraph B.(3). Please confirm that the Non-anesthesia Related Services Conversion Factor of $29.67 applies to all physician services. If not, the State must amend its approved State plan to include information to describe its payment rates for these services. To achieve this end, the State could insert language such as the following:

   "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of *(ex. case management for persons with chronic mental illness)*. The agency's fee schedule rate was set as of *(insert date here)* and is effective for services provided on or after that date. All rates are published *(ex. on the agency's website)*."

3. Attachment 4.19-B, page 20.9, paragraph IV.B.(1). The third paragraph in this section reads: "The fixed upper limit for the procedure shall be consistent with the general array of rates for the type of service. "General array of fixed rates" means that the rate upper limit set for the procedure will be at the same relative Level, so far as possible, as the rates for the procedures which are similar in nature. The listing of similar services is referred to as the "general array." The actual upper limit is derived by using not less than 3 other sources such as Medicare, Workman's Compensation, other federal programs, other state or local governments, and health insurance organizations or if a rate is not available from these sources then we solicit rates from at least 3 of the highest volume instate providers of the services. After obtaining at least 3 rates, the rates are added together then divided by the number of rates to obtain an average rate which is then compared to similar procedures paid in comparable circumstances by the Medicaid program to set the upper limit." This paragraph is not comprehensive in that it does not provide enough information to determine the actual rate. To achieve this end, the State could include the effective date fee schedule language described in item 2 above.

4. Attachment 4.19-B, page 20.9, paragraph IV.B.(3). This paragraph is not comprehensive in that it does not contain a comprehensive description of the rate methodology (i.e., it does not describe how the State is increasing the limit in effect on 6/30/00). The State either needs to specify how the limit is increased (i.e., 5% per year) or include the effective date fee schedule language described in item 2 above. Also, please correct the last word in the 1st sentence to read "be".

Within 90 days of the date of this letter, the State is required to submit a State plan amendment that resolves the issues, or a corrective action plan to resolve the issues, whichever is appropriate. During the 90-day period, we are happy to provide any technical assistance that the State requires. State plans that are not in compliance with requirements referenced above are grounds for initiating a formal compliance process.

If you have any questions or need any further assistance, please contact Darlene Noonan at (404) 562-2707.

Sincerely,

Jackie Glaze

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

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 lesser of the physicians' usual and customary actual billed charges or 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.

(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 lesser of the physicians' usual and customary actual billed charges or 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 invertebral 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 anitbiotics 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 practice related service provided by a physician assistant, the participating physician shall be reimbursed at the lesser of the usual and customary actual billed charge or 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.

IV. Vision Care Services

A. Definitions.

For purposes of determination of payment, "usual and customary actually billed charge" refers to the uniform amount the individual optometrist or ophthalmic dispenser charges in the majority of cases for a specific procedure or service.

B. Reimbursement for Covered Procedures and Materials for Optometrists.

(1) Reimbursement for covered services, within the optometrist's scope of licensure, except materials and laboratory services shall be based on the lesser of the optometrists' usual and customary actual billed charges or 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) with a conversion factor of $29.67.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Optometry. The agency's fee schedule rate was set as of January 1, 2011 and is effective for services provided on or after that date. The agency's fee schedules are reviewed annually and updated as necessary. All rates are published on the Department for Medicaid Services web site at http://chfs.ky.gov/dms/fee.htm.

(2) With the exception of rates paid for dispensing services, fixed upper limits for vision services shall be calculated using the same RBRVS units as those used in the physicians services program, with the units multiplied by the "all other services" conversion factor to arrive at the fixed upper limit for each procedure.

(3) Reimbursement for materials (eyeglasses or part of eyeglasses) shall be made at the lesser of the optical laboratory cost of the materials or the upper limits for materials as set by the department. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for post-payment review. The agency upper limits for materials are set based on the agency's best estimate or reasonable and economical rates at which the materials are widely and

consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometry Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

(4) Laboratory services shall be reimbursed at the lesser of the actual billed amount or the Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-live (65) percent of usual and customary actual billed charges.

C. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers

Reimbursement for a covered service within the ophthalmic dispenser's scope of licensure shall be as described in Section B (above).

D Effect of Third Party Liability

When payment for a covered service is due and payable from a third party source, such as private insurance, or some other third party with a legal obligation to pay, the amount payable by the department shall be reduced by the amount of the third party payment.

XXXV Chiropractic 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) "Covered chiropractic services" shall include the following:

(a) An evaluation and management service;
(b) Chiropractic manipulative treatment;
(c) Diagnostic X-rays;
(d) Application of a hot or cold pack to one (1) or more areas;
(e) Application of mechanical traction to one (1) or more areas;
(f) Application of electrical stimulation to one (1) or more areas; and
(g) Application of ultrasound to one (1) or more areas.

B. Reimbursement

(1) Payment for covered chiropractor's services shall be based on the lesser of the chiropractor's usual and customary actual billed charges or 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 for the procedure consistent with the general rate setting methodology. 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. RBRVS units shall be multiplied by the Non-anesthesia Related Services dollar conversion factor of $29.67 to arrive at the fixed upper limit.

C. Reimbursement Exceptions.

(1) 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.

(2) For services provided on or after July 1, 1990, chiropractors 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 lesser of the chiropractors' usual and customary actual billed charges or up to 125 percent of the fixed upper limit per procedure established by the Department.

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~~Fixed upper limits not determined in accordance with the RBRVS methodology (due to factors such as availability) shall be set by the department using the following methodology.~~

~~The fixed upper limit for the procedure shall be consistent with the general array of rates for the type of service. "General array of fixed rates" means that the rate upper limit set for the procedure will be at the same relative Level, so far as possible, as the rates for procedures which are similar in nature. The listing of similar services is referred to as the "general array." The actual upper limit is derived by using not less than 3 other sources such as Medicare, Workman's Compensation, other federal programs, other state or local governments, and health insurance organizations or if a rate is not available from these sources then we solicit rates from at least 3 of the highest volume instate providers of the services. After obtaining at least 3 rates, the rates are added together then divided by the number of rates to obtain an average rate which is then compared to similar procedures paid in comparable circumstances by the Medicaid program to set the upper limit.~~Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Optometry. The agency's fee schedule rate was set as of January 1, 2011 and is effective for services provided on or after that date. The agency's fee schedules are reviewed annually and updated as necessary. All rates are published on the Department for Medicaid Services web site at http://chfs.ky.gov/dms/fee.htm.

(2) With the exception of rates paid for dispensing services, fixed upper limits for vision services shall be calculated using the same RBRVS units as those used in the physicians services program, with the units multiplied by the "all other services" conversion factor to arrive at the fixed upper limit for each procedure.

~~(3) The upper payment limit for the following dispensing services shall be established by increasing the limit in effect on 6/30/00 to a fee no less than the Medicare allowable fee established for the service.~~

~~(a) Fitting of spectacles;~~

~~(b) Special spectacles fitting; and~~

~~(c) Repair and adjustment of spectacles.~~

~~(4)~~(3) Reimbursement for materials (eyeglasses or part of eyeglasses) shall be made at the lesser of the optical laboratory cost of the materials ~~not to exceed~~ or the upper limits for materials as set by the department. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for post-payment review. The agency upper limits for materials are set based on the agency's best estimate or reasonable and economical rates at which the materials are widely and

consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometry Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

(~~5~~4) Laboratory services shall be reimbursed at the lesser of the actual billed amount ~~not to exceed~~ or the Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-live (65) percent of usual and customary actual billed charges.

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(3) "Covered chiropractic services" shall include the following:

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(2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. 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. RBRVS units shall be multiplied by the Non-anesthesia Related Services dollar conversion factor of $29.67 to arrive at the fixed upper limit.

C. Reimbursement Exceptions.

(1) 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.

(2) For services provided on or after July 1, 1990, chiropractors 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 lesser of the chiropractors' usual and customary actual billed charges or up to 125 percent of the fixed upper limit per procedure established by the Department.

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 lesser of the physicians' usual and customary actual billed charges ~~up to~~or 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.

(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 lesser of the physicians' usual and customary actual billed charges ~~up to~~or 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 invertebral 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 anitbiotics 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 practice related service provided by a physician assistant, the participating physician shall be reimbursed at the lesser of the usual and customary actual billed charge ~~up to~~or 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.