



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

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September 3, 2014

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: State Plan Amendment 14-004 - Technical Corrections for Physician Reimbursement and Immunizations in Physician Office

Dear Ms. Glaze:

This letter is in response to your Request for Additional Information (RAI) issued on August 8, 2014 regarding KY SPA 14-004. Please see our responses to our comments below and revised State Plan pages that are attached.

1. Attachment 4.19-B, Page 20.3.B.(1), 3rd Sentence

This sentence currently reads, "The agency's fee schedule rate was set as of (insert current date) and is effective for services provided on or after that date and are updated annually on January 1st or thirty (30) days following the release of the revised CPT Codes from the American Medical Association, whichever is earlier."

Please include the date the fee schedule rate was set.

DMS Response - Revision has been made to the attached page.

2. Attachment 4.19-B, Page 20.3, B.(2)

This paragraph currently reads, "If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be thirty-three (33)



percent of the usual and customary billed charge. After the first quarter, Medicaid will reimburse thirty-three (33) percent of the weighted average.”

CMS normally does not consider reimbursement of billed charges a comprehensive payment methodology as charges vary by provider. Please describe the services that would not be included in the physician fee schedule. Additionally, please explain why the state has not developed a fee for those services.

DMS Response - DMS had changed this to read “If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be forty-five (45) percent of the billed charge. After the first quarter, Medicaid will establish a reimbursement rate based on the average payments for each procedure code during that quarter. The rate for that code will then be added to our Medicaid Physician Fee Schedule. If Medicare develops RBRVS Units for a procedure code, Kentucky will revise our Fee Schedule using the Medicare RBRVS Units”

While we understand that CMS does not consider reimbursement of bill charges a comprehensive payment methodology, without any historical data to determine a rate, it would be difficult to establish a rate, which we assume is why Medicare does not have an established rate. We do not believe this will be a huge impact because the reimbursement that DMS would be making would only be for Medicaid recipients that are in the Fee-For-Service Medicaid. Furthermore, upon a review of our CPT codes, we have found there are only 93 that Medicare currently does not have a reimbursement listed for KY to use to determine the Medicaid reimbursement.

3. Attachment 4.19-B, Page 20.4, Item (9) and Page 20.24, Item (2)c

Attachment 4.19-B, Page 20.4, Item (9) currently reads, “Certain injectable antibiotics and antineoplastics, and contraceptives shall be reimbursed at the less of the actual billed charge or at the average wholesale prices of the medication supply minus ten (10) percent.”

Attachment 4.19-B, Page 20.24 (Item (2)c currently reads, “Injectable antibiotics. antineoplastic chemotherapy. and contraceptives shall be reimbursed at the lesser of:

1. The actual billed charge; or
 2. The average wholesale price of the medication supply minus ten (10) percent.”
- A. As this reimbursement methodology is related to covered outpatient drugs, please relocate item (8) from page 20.4 and item (2) c from page 20.24 to the appropriate section of Attachment 4.19-B (12 - Prescribed Drugs).

DMS Response - Please see attached State Plan pages. Kentucky has moved the language as requested.

- B. In response to the informal questions the state proposed to change the language to specify “A physician injectable drug product that is administered by a physician or their authorized agent during an in office procedure, and is federally rebateable pursuant to manufacturer agreement, and is identified on the Kentucky Physician Injectable Drug List (posted on the Kentucky Medicaid website and periodically updated) shall be reimbursed at the less of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent”. CMS has no concerns with this revised language as long as it is moved to the appropriate section of Attachment 4.19-B (12 - Prescribed Drugs).

DMS Response - Please see attached State Plan pages. Kentucky has moved the language as requested.

- C. Additionally, since the state is proposing to change the language to specify “a physician injectable drug product that is administered by a physician or their authorized agent during an in office procedure...”, it appears as if this would cover both the physician and the nurse practitioner as it is our understanding that a nurse practitioner practices under the supervision of a physician. If that is not the case, the state could revise the language to specify physician, nurse practitioner or authorized agent; thereby eliminating the need for this paragraph.

DMS Response - Please see attached State Plan pages. Kentucky has moved the language as requested and we have included a cross reference in both the Physician Reimbursement and Advanced Registered Nurse Practitioner Sections to refer people to the pharmacy reimbursement for physician injectable drugs.

4. Attachment 4.19-B, Page 20.13-E, Laboratory Services, 1st Paragraph

This paragraph currently reads, “The State Agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics for covered laboratory services rendered on the basis of the allowable payment rates set by Medicare.”

Based on the state’s response to CMS’s informal comments, it appears as if the state is reimbursing these providers based on the current Medicare Lab Fee Schedule. If so, please change this to read, “... covered laboratory services rendered based on the current Medicare Clinical Laboratory Fee Schedule.” If this is not the case, please include the release date of the fee schedule the state is using.

DMS Response - DMS has made changes on the attached State Plan pages.

5. Attachment 4.19-B, Page 20.13-E, Laboratory Services, 2nd Paragraph, 1st Sentence

This sentence currently reads, "For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the most current release of the 60% Medicare Clinical Laboratory Fee Schedule."

Please change this to read, "...physician (clinical diagnostic) laboratory services shall be reimbursed 60% of the current Medicare Clinical Laboratory Fee Schedule."

DMS Response - The requested changes have been made on the attached State Plan pages.

6. Attachment 4.19-B, page 20.13-E, Family Planning, 2nd Sentence

This sentence currently reads, "Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall not exceed the following amount:"

The phrase "shall not exceed" does not meet the comprehensiveness requirements. The state can either say it will reimburse the actual rates listed (i.e., shall be reimbursed the following amounts) or some other comprehensive methodology.

DMS Response - We have changed the language to state we will reimburse at the lesser of the billed amount or the amounts listed on the State Plan page.

Any questions or correspondence relating to this SPA should be sent to Sharley Hughes.

Please let me know if you have any questions relating to this matter.

Sincerely,



Lawrence Kissner
Commissioner

LK/sjh

Enclosure

Methods and Standards for Establishing Payment Rates — Other Types of Care

I. Drugs

B. Payment Limits — Payment for the cost of drugs shall be the lesser of:

6. The department shall reimburse for drugs at the lesser of:

- Branded Drugs: WAC + 2% (plus dispensing fee) OR
- Generic Drugs: WAC + 3.2 % (plus dispensing fee) OR
- FUL + dispense fee OR
- MAC + dispense fee OR
- Usual & Customary (U & C)

7. For nursing facility residents meeting Medicaid patient status, an incentive of two (2) cents per unit dose shall be paid to long term care, personal care, and supports for community living pharmacists for repackaging a non-unit dose drug in unit dose form.

8. Injectable Drugs administered in a physician's office

A physician injectable drug product that is administered by a physician or their authorized agent during an in office procedure, and is federally rebateable pursuant to manufacturer agreement, and is identified on the Kentucky Physician Injectable Drug List (posted on the Kentucky Medicaid website and periodically updated) 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.

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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 physician services shall be based on the lesser of the physicians' usual and customary actual billed charges or the Medicaid Physician Fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician Services. The agency's fee schedule rate was set as of January 1, 2014 and is effective for services provided on or after that date and are updated annually on January 1st or thirty (30) days following the release of the revised CPT Codes from the American Medical Association, whichever is earlier. All rates are published on the agency's website at <http://www.chfs.ky.gov/dms/fee.htm>.
- (2) ~~If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be forty-five (45) percent of the billed charge. After the first quarter, Medicaid will establish a reimbursement rate based on the average payments for each procedure code during that quarter. The rate for that code will then be added to our Medicaid Physician Fee Schedule. If Medicare develops RBRVS Units for a procedure code, Kentucky will revise our Fee Schedule using the Medicare RBRVS Units.~~~~If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be forty-five (45) percent of the usual and customary billed charge. After the first quarter, Medicaid will establish a reimbursement rate based on the average payments for each procedure code during that quarter. The rate for that code will then be added to our Medicaid Physician Fee Schedule. If Medicare develops a rate Kentucky will revise our~~

Fee Schedule to match the Medicare Rate. Once the rate is established, the state will go back and make adjustments if it is determined the established rate is substantially different than the rate the state reimbursed during the first quarter.

TN No: 14-004

Supersedes

TN No: 11-006

Approval Date: _____

Effective Date: April 1, 2014

- (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 |

C. Reimbursement Exceptions

- (1) Physicians, who are enrolled in the Vaccines for Children (VFC) Program, will only be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the VFC Program to provide immunizations for Medicaid recipients under the age of nineteen (19). Vaccine costs for any VFC specified immunization will not be reimbursed for the physicians who are enrolled in the VFC Program. For additional information on vaccine administration, please see Att. 4.19-B, Page 20.5(4).

- (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

- (5) Procedures which are specified by Medicare and published annually in the Federal Register, which are commonly performed in the physician's office, will be reimbursed adjusted rates to take into account the change in usual site of service (facility vs. non-facility based on Medicare Site of Service designation) and are subject to the outpatient upper payment limit.
- (6) Payments for the injection procedure for chemonucleolysis of intervertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or \$793.50.
- (7) Specified family planning procedures in the physician office setting shall be reimbursed at the lesser of the actual billed charges or the Medicaid Physician Fee Schedule plus actual cost of the supply minus ten percent.
- (8) ~~For information relating to A-physician injectable drug products that is-are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b), and is federally rebateable pursuant to manufacturer agreement, and is identified on the Kentucky Physician Injectable Drug List (posted on the Kentucky Medicaid website and periodically updated) 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.~~
- (9) 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).
- (10) For practice related services provided by a physician assistant, the participating physician shall be reimbursed at the lesser of the usual and customary charges actual billed charges or 75 percent of the Medicaid Physician Fee Schedule per procedure
- (11) 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.
- (12) 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.
- (13) 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
- (14) If more than one procedure is performed at the same time, the provider shall be reimbursed one hundred (100) percent of the Medicaid Physician Fee Schedule for the first procedure and fifty (50) percent of the Medicaid Physician Fee Schedule for each additional procedure.
- (15) 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).

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- (16) Physicians, who are not enrolled in the VFC Program, will be reimbursed for the administration of immunizations, to include the influenza vaccine, as well as the vaccine cost, as defined in the Center for Disease Control (CDC) Vaccine Price List published as of January 1, 2014 to a Medicaid recipient of any age.
 - (17) 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.
 - (18) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of \$150.
 - (19) 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.
 - (20) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 will be reimbursed at eighty-seven and one half (87.5) percent of Medicare Fee Schedule in effect as of January 1, 2006.

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.
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B. Reimbursement

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- (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:

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- (4) Payment for individuals eligible for coverage under Medicare part B is made, in accordance with Sections A and B and items (1) through

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- (5) Procedures which are specified by Medicare and published annually in the Federal Register, which are commonly performed in the physician's office, will be reimbursed adjusted rates to take into account the change in usual site of service (facility vs. non-facility based on Medicare Site of Service designation) and are subject to the outpatient upper payment limit.
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 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.
- (13) 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
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 - (19) 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.
 - (20) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 will be reimbursed at eighty-seven and one half (87.5) percent of Medicare Fee Schedule in effect as of January 1, 2006.

XI. Laboratory Services

Eff. The State Agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics for covered laboratory services rendered ~~on the basis of the allowable payment rates set by Medicare based on the Medicare Clinical Laboratory Fee Schedule.~~

XII For services provided on or after July 1, 1990, physician ~~(clinical diagnostic)~~ laboratory services shall be reimbursed ~~based on the most current release of the 60% of the current Medicare Lab-Clinical Fee Laboratory Fee Schedule.~~ 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.

XIII Family Planning Clinics

Effective 7/1/87, the State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR 447.32. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall ~~not exceed the~~ be reimbursed the lesser of the actual billed amount or the below listed following amounts:

| | Physicians | ARNP |
|---|------------|---------|
| Initial Clinic Visit | \$50.00 | \$37.75 |
| Annual Clinic Visit | \$60.00 | \$45.00 |
| Follow-up Visit with Pelvic Examination | \$25.00 | \$18.75 |
| Follow-up Visit without Pelvic Examination | \$20.00 | \$15.00 |
| Counseling Visit | \$13.00 | \$13.00 |
| Counseling Visit w/3 months contraceptive supply | \$17.00 | \$17.00 |
| Counseling Visit w/6 months contraceptive supply | \$20.00 | \$20.00 |
| Supply Only Visit – Actual acquisition cost of contraceptive supplies dispensed | | |

XI. Laboratory Services

Eff. The State Agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics for covered laboratory services rendered based on the Medicare Clinical Laboratory Fee Schedule.

XII For services provided on or after July 1, 1990, physician (clinical diagnostic) laboratory services shall be reimbursed 60% of the current Medicare Clinical Laboratory Fee Schedule. 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.

XIII Family Planning Clinics

Effective 7/1/87, the State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR 447.32. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall be reimbursed the lesser of the actual billed amount or the below listed amounts:

| | Physicians | ARNP |
|---|------------|---------|
| Initial Clinic Visit | \$50.00 | \$37.75 |
| Annual Clinic Visit | \$60.00 | \$45.00 |
| Follow-up Visit with Pelvic Examination | \$25.00 | \$18.75 |
| Follow-up Visit without Pelvic Examination | \$20.00 | \$15.00 |
| Counseling Visit | \$13.00 | \$13.00 |
| Counseling Visit w/3 months contraceptive supply | \$17.00 | \$17.00 |
| Counseling Visit w/6 months contraceptive supply | \$20.00 | \$20.00 |
| Supply Only Visit – Actual acquisition cost of contraceptive supplies dispensed | | |

XXV. Advanced Registered Nurse Practitioner Services

(1) Reimbursement

- a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed ARNP.
- b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
 - 1. The ARNP's actual billed charge for the service; or
 - 2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.
- c. An ARNP employed by a primary care center, federally qualified health center, hospital, or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

- a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP, per recipient, per date of service.
- b. The cost of a vaccine provided to a physician or other provider enrolled in the Vaccines for Children (VFC) Program and available free through the Vaccines for Children Program shall not be reimbursed.
- c. ~~For information relating to physician injectable drug products that are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b). Injectable antibiotics, antineoplastic chemotherapy, and contraceptives shall be reimbursed at the lesser of:~~
 - ~~1. The actual billed charge; or~~
 - ~~2. The average wholesale price of the medication supply minus ten (10) percent.~~

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XXV. Advanced Registered Nurse Practitioner Services

(1) Reimbursement

- a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed ARNP.
- b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
 1. The ARNP's actual billed charge for the service; or
 2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.
- c. An ARNP employed by a primary care center, federally qualified health center, hospital, or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

- a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP, per recipient, per date of service.
- b. The cost of a vaccine provided to a physician or other provider enrolled in the Vaccines for Children (VFC) Program and available free through the Vaccines for Children Program shall not be reimbursed.
- c. For information relating to physician injectable drug products that are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b).