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

I. Drugs

A. Reimbursement

1. Participating pharmacies are reimbursed for the cost of the drug plus a dispensing fee. Payments shall not exceed the upper limits specified in 42 CFR 447.331 through 447.334.
2. Participating dispensing physicians are reimbursed for the cost of the drug only.
3. Providers will be reimbursed only for drugs supplied from pharmaceutical manufacturers who have signed a rebate agreement.

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

1. The Federal Maximum Allowable Cost (FMAC) of the drug for multiple source drugs other than those brand name drugs for which a prescriber has certified in writing as "brand medically necessary" or "brand Necessary";
2. The State Maximum Allowable Cost (SMAC). A SMAC may be established for any drug for which two or more A-rated therapeutically equivalent, multi-source, non-innovator drugs with a significant cost difference exist. The SMAC will be determined taking into account drug price status (non-rebatable, rebatable), marketplace status (obsolete, regional availability), equivalency rating (A-rated), and relative comparable pricing. Other factors considered are clinical indications of generic substitution, utilization and availability in the marketplace. The source of comparable drug prices will be nationally recognized comprehensive data files maintained by a vendor under contract with the Department for Medicaid Services. Resources accessed to determine SMAC include Average Wholesale Price, Wholesale Acquisition Cost, and Direct Price (to retail pharmacies) with weights applied based on the distribution of the volume purchased.
 - a. Multiple drug pricing resources are utilized to determine the estimated acquisition cost for the generic drugs. These resources include pharmacy providers, wholesalers, drug file vendors such as First Data Bank, and pharmaceutical manufacturers;

- b. The estimated acquisition cost for each product is maintained in a MAC pricing file database;
 - c. Products are then sorted into drug groups by GCN, which denotes the same generic name, strength, and dosage form;
 - d. A filter is applied to remove all drug products that are obsolete, are not therapeutically equivalent, or are not available in the marketplace;
 - e. The acquisition cost for the remaining drug products are analyzed to produce the estimated acquisition cost for the drug group giving due consideration (which consists of utilization and availability in the marketplace) to the lower cost products;
 - f. The resulting estimated acquisition cost is used to produce a SMAC rate. The resulting SMAC is always greater than the pharmacy provider actual acquisition cost and is designed to provide the pharmacy with an appropriate profit margin;
 - g. The SMAC rate will then be applied to all brand and generic drug products in that specific GCN;
 - h. The SMAC file is updated monthly. Kentucky's MAC list may be downloaded from the following website:
<http://kentucky.fhsc.com/providers/mac.asp> ;
 - i. A pharmacy provider may appeal a SMAC price;
3. Effective February 23, 2005, the Estimated Acquisition Cost (EAC) for a generic drug shall equal the average wholesale price (AWP) minus fourteen (14) percent and for a brand drug shall equal the AWP minus fifteen (15) percent; or
4. The provider's usual and customary charge.

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.

Methods and Standards for Establishing Payment Rates – Other Types of CareC. Dispensing Fee

1. When establishing dispensing fees, the Department takes into consideration the conclusions of a report regarding the dispensing of prescription medications to persons eligible for Medicaid benefits. The report is based upon a survey of pharmacy dispensing costs in the Commonwealth of Kentucky, a review of academic literature, and the reimbursement rates of other payers. The report, required by state law, is submitted every three (3) years to the Governor and to the Legislative Research Commission. Utilizing the above information the Department establishes a reasonable dispensing fee.

Effective February 23, 2005, the dispensing fee for a generic drug prescription is \$5.00 and for a brand name drug prescription is \$4.50. The dispensing fee is applied to outpatient pharmacies and to long term care facilities.

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

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 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
Neuroaxial labor anesthesia for a vaginal delivery or cesarean section	\$350.00
Additional anesthesia for cesarean delivery following neuroaxial labor anesthesia for vaginal delivery	\$25.00
Additional anesthesia for cesarean hysterectomy following neuroaxial 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 RHRVS 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 Art 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 ("Y" using actual data from the most recent completed ("Y". 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 Art 3.1-A, p. 7.2.1 & Art 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.

III. Dental Services

A. Definitions

- (1) For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.
- (2) "Dental School Faculty Dentist" is a dentist who is employed by a state-supported school of dentistry (for teaching and clinical responsibilities) and who receives their earnings statement (W-2) from the state-supported school of dentistry for their teaching and clinical responsibilities.

B. Reimbursement for Outpatient and Inpatient Services

- (1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist's actual billed charge not to exceed the fixed upper limit per procedure established by the department.
- (2) With the exceptions specified in section (3), (4), and (5), the upper payment limit per procedure shall be established by increasing the limit in effect on 6/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states based upon a survey of Dental Fees by the American Dental Association.
- (3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper limit by the following:
 - a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen's Compensation, private insurers or three (3) high volume Medicaid providers;
 - b. An average limit based upon these rates will be calculated; and
 - c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.
- (4) The following reimbursement shall apply:
 - a. Orthodontic Consultation, \$112.00, except that a fixed fee of \$56.00 shall be paid if:
 1. The provider is referring a recipient to a medical specialist;
 2. The prior authorization for orthodontic services is not approved; or
 3. A request for prior authorization for orthodontic services is not made.
 - b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, \$1,367 for orthodontists and \$1,234 for general dentists.
 - c. Prior authorized orthodontic services for moderately severe disabling malocclusions, \$7,825 for orthodontists and \$1,649 for general dentists.
 - d. Prior authorized orthodontic services for severe disabling malocclusions, \$2,754 for orthodontists and \$2,455 for general dentists.
 - e. Prior authorized services for Temporomandibular Joint (TMJ) therapy, an assessed rate per service not to exceed \$424.
- (5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.

- (6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:
- The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and
 - In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.
- (7) Supplemental payments will be made for services provided by dental school faculty dentists either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan dentists 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.
- To qualify for a supplemental payment under this section, dentists must meet the following criteria:
 - Be Kentucky licensed dentists;
 - Be enrolled as Kentucky Medicaid providers; and
 - Be Dental School Faculty Dentists as defined in Att 4.19-B, page 20.6, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.
 - For dentists 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 dentists and the average rate paid for the services by commercial insurers. The payment amounts are determined by:
 - 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;
 - 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
 - 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.
 - 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 dentists meeting the criteria in Part (a) above. If a dentist 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.
 - 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.
- C. Assurances. The State hereby assures that payment for dentists 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.

IV. Vision Care Services**A. Definitions**

For purposes of determination of payment, "usual and customary actual 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 optometrists' 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) with a conversion factor of 529.67.

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 in-state 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.

- (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) Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made if the optical laboratory cost of the materials not to exceed 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 of 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) Laboratory services shall be reimbursed at the actual billed amount not to exceed Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-five (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.

- F. Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

V. Hearing Services

- A. The State Agency shall reimburse a participating audiologist at usual and customary actual billed charges up to the fixed upper limit per procedure established by the Kentucky Medicaid Fee Schedule with a conversion factor of \$29.67.

Audiologists shall be entitled to the same dispensing fee for hearing aids as shown in Section B.

B. Hearing Aid Dealers.

1. If a manufacturer's invoice price is submitted for a hearing instrument billed to the department, the department shall reimburse the lesser of:
 - a) The manufacturer's invoice price plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date;
 - b) The actual hearing instrument specialist's cost plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date; or
 - c) The suggested retail price submitted by the manufacturer for the hearing instrument.
2. If a manufacturer's invoice price of a hearing instrument billed to the department does not match the manufacturer's submitted price schedule which includes the manufacturer's invoice price for the hearing instrument, the department shall reimburse the participating specialist in hearing instruments at the lesser of:
 - a) The lowest price submitted for a comparable hearing instrument plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date;
 - b) The actual specialist in hearing instruments' cost plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date; or
 - c) The lowest suggested retail price submitted by a manufacturer for a comparable instrument.

- C. Replacement Cord Reimbursement. The department shall reimburse for a replacement cord at the hearing instrument specialist's cost plus a professional fee set at \$21.50.

- D. Hearing Instrument Repair Reimbursement. The department shall reimburse a hearing instrument specialist in hearing instruments for a hearing instrument repair:
1. On the basis of the manufacturer's charge for repair or replacement of parts;
 2. Plus the hearing instrument specialist's cost for postage and insurance relative to the repair;
 3. Plus a professional fee of \$21.50; and
 4. Not to exceed the price of a new hearing instrument.

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2. If the manufacturer of the hearing aid billed to the program has not submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse that participating hearing aid dealer at the lessors of:
- a) The lowest dealer price submitted for a comparable hearing aid plus a professional fee of seventy-five (75) dollars or at the actual dealer cost plus a professional fee of seventy-five (75) dollars or twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date;
 - b) The actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or
 - c) The lowest suggested retail price submitted for a comparable aid. A comparable aid is defined as an aid falling within the general classification of fitting type, i.e., body, behind-the-ear, in-the-ear, eyeglasses.
- c. Cords. The State Agency shall make payment for a replacement cord at the dealer's cost, plus professional fee set at the fixed upper limit
- D. Hearing Aid Repairs. The State Agency shall reimburse a hearing aid dealer for a hearing aid repair on the basis of the manufacturer's charge for repair or replacement of parts, plus the dealer's cost for postage and insurance relative to the repair, plus a professional fee set at the fixed upper limit.

VI. Screening Services

- A. The state agency shall reimburse providers for screening services in accordance with their usual payment procedures outlined in this state plan.
- B. The state agency shall reimburse screening clinics or agencies with the lesser of the payment procedure for physician's services described in Attachment 4.19-B, page 20.3, or the usual and customary charge of the provider for the service.

VI-A. Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

- (1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services) the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:
- (a) 1905(a)(1), inpatient hospital services;
 - (b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
 - (c) 1905(a)(3), other laboratory and X-ray services;
 - (d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
 - (e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
 - (f) 1905(a)(6), medical care by other licensed practitioners;
 - (g) 1905(a)(7), home health care services;
 - (h) 1905(a)(9), clinic services;
 - (i) 1905(a)(10), dental services;
 - (j) 1905(a)(11), physical therapy and related services;
 - (k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
 - (l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
 - (m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
 - (n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
 - (o) 1905(a)(17), nurse-midwife services;
 - (p) 1905(a)(18), hospice care;
 - (q) 1905(a)(19), case management services; and
 - (r) 1905(a)(24), other medical and remedial care specified by the Secretary. ²² *PEI HIFA 5-15-92*
- (2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21 the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100% of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

- (a) Any service described in 1. above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
- (b) 1905(a)(8), private duty nursing services;
- (c) 1905(a)(20), respiratory care services;
- (d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
- (e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitoriums, and personal care services in a recipient's home.

VI: Transportation ServicesA. Ambulance Services

- (1) The department shall reimburse an ambulance service at the lesser of the provider's usual and customary charge or an upper limit established by the department for the service. Payment for an ambulance service shall be contingent upon a statement of medical necessity.
- (2) The upper limit for air ambulance transportation shall be set at \$3,500 per one (1) way trip.
- (3) The upper limit for an ambulance service (other than air ambulance transportation) shall be calculated by adding a base rate, mileage allowance, and flat rate fee as follows:
 - (a) The base rate for Advanced Life Support (ALS) emergency ambulance transportation to the emergency room of a hospital shall be set at \$110 per one (1) way trip; the mileage allowance for trips shall be four (4) dollars per mile for mileage from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional allowance for mileage.
 - (b) The base rate for Basic Life Support (BLS) emergency ambulance transportation to the emergency room of a hospital shall be set at eighty-two dollars and fifty cents (82.50) per one (1) way trip; the mileage allowance for trips shall be three (3) dollars per mile for mileage from mile one (1); a flat rate of twenty (20) dollars shall be set for each additional recipient with no additional allowance for mileage.
 - (c) The base rate for any ALS or BLS providing emergency ambulance transportation to an appropriate medical facility or provider other than the emergency room of a hospital shall be set at sixty (60) dollars per one (1) way trip; the mileage allowance for trips shall be two (2) dollars and fifty (50) cents per mile for mileage from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage.
 - (d) The base rate for BLS emergency ambulance transportation to the emergency room of a hospital during which the services of an ALS Medical First Response provider is required to stabilize the patient shall be \$110; the mileage allowance shall be four (4) dollars per mile from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional rate for mileage.

- (c) The base rate for BLS emergency ambulance transportation to a medical facility or provider other than the emergency room of a hospital during which the services of an ALS Medical First Response provider are required shall be sixty (60) dollars; the mileage allowance shall be two (2) dollars and fifty (50) cents per mile from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage.
- (f) The base rate for non-emergency ambulance transportation during which the recipient requires no medical care during transport shall be fifty-five (55) dollars and the mileage allowance shall be two (2) dollars per mile from mile one (1).
- (g) The cost of other itemized supplies for ALS or BLS emergency transportation services shall be the actual cost as reflected on the transportation provider's invoice which shall be maintained in the provider's files and shall be produced upon request by the department. Each quarter, the department shall review a random sample of invoices to verify reported costs.
- (4) In addition to the rates described in paragraph (3) above, administration of oxygen during an ambulance transportation service (other than air ambulance transportation) shall be reimbursed at a flat rate of ten (10) dollars per one (1) way trip when medically necessary.
- (5) Reimbursement for an ambulance service shall not be made if a recipient receives transportation free as the result of a local subscription fee or tax.
- B. Commercial Transportation Carriers
When a broker has been terminated, the department shall reimburse participating commercial transportation carriers at usual commercial rates on an interim basis (pending selection of a new broker) with limitations as follows:
- (1) For taxi services provided in regulated areas the provider shall be reimbursed the normal passenger rate charged to the general public for a one (1) way trip regardless of the number of Medicaid eligible recipients transported when the trip is within the medical service area. The taxi shall be paid the single passenger rate regardless of the number of additional passengers.
- (2) For taxi services in those areas of the state where taxi rates are not regulated by the appropriate local rate setting authority, and for taxi services in regulated areas when they go outside the medical service area, the provider shall be reimbursed the normal passenger rate charged the general public for a single passenger (without payment for additional passengers, if any) up to the upper limit; reimbursement for transport of a parent or attendant shall be considered included within the upper limit allowed for the trip. The upper limit for a taxi transporting a recipient shall be:

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- (a) The usual and customary charge up to a maximum of six (6) dollars for trips of five (5) miles or less, one (1) way, loaded miles.
- (b) The usual and customary charge up to a maximum of twelve (12) dollars for trips of six (6) to ten (10) miles, one (1) way, loaded miles.
- (c) The usual and customary charge up to a maximum of twenty (20) dollars for trips of eleven (11) to twenty-five (25) miles, one (1) way, loaded miles.
- (d) The usual and customary charge up to a maximum of thirty (30) dollars for trips of twenty-six (26) miles to fifty (50) miles, one (1) way, loaded miles.
- (e) For trips of fifty-one (51) miles or above shall be the lesser of the usual and customary charge or an amount derived by multiplying one (1) dollar by the actual number of miles, not to exceed a maximum of seventy-five (75) dollars per trip, one (1) way, loaded miles.

C. Private Automobile Carriers.

- (1) The department shall reimburse private automobile carriers at the basic rate of twenty-two (22) cents per mile plus a flat fee of four (4) dollars per recipient if waiting time is required. For round trips of less than five (5) miles the rate shall be computed on the basis of a maximum allowable fee of six (6) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. Private automobile carriers shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing reimbursable medical transportation services.
- (2) For round trips of five (5) to twenty-five (25) miles the rate for private automobile carriers shall be computed on the basis of maximum allowable fee of ten (10) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. The maximum allowable fee rates shall not be utilized in situations where mileage is paid.

(3) Even though the maximum allowable fee rate when computed on the basis of twenty-two (22) cents per mile plus four (4) dollars for waiting time would not equal the six (6) dollars or ten (10) dollars allowable amounts, the higher amount is paid to encourage private automobile carriers to provide necessary medical transportation. Additionally, nothing in this section requires the department to pay the amounts specified if the private automobile carrier expresses a preference for reimbursement in a lesser amount; then the lesser amount shall be paid. Toll charges shall be reimbursable when presented with a receipt.

(4) Waiting time shall be a reimbursable component of the private automobile carrier transportation fee only if waiting time occurs. If waiting time occurs due to admittance of the recipient into the medical institution, the private automobile carrier may be reimbursed for the return trip to the point of recipient pick-up as though the recipient were in the vehicle; that is, the total reimbursable amount shall be computed on the basis of the maximum allowable fee or mileage rate plus waiting time. Waiting time shall not be paid for the attendant or caretaker relative (e.g., mother, father) who is accompanying the recipient and not personally being transported for Medicaid covered service.

(5) If a private automobile carrier is transporting more than one (1) recipient, only one (1) mileage payment shall be allowed. Mileage shall be computed on the basis of the distance between the most remote recipient and the most remote medical service utilized; and will include any necessary additional mileage to pickup and discharge the additional recipients.

D. Non-Commercial Group Carriers.

(1) The department shall reimburse participating non-commercial group carriers based on actual reasonable, allowable cost to the provider based on cost data submitted to the department by the provider.

(2) The minimum rate shall be twenty (20) cents per recipient per mile transported and the rate upper limit shall be fifty (50) cents per recipient per mile transported.

(3) Payment for a parent or other attendant shall be at the usual recipient rate.

E. Specialty Carriers.

(1) Participating specialty carriers shall be reimbursed at the lesser of the following rates:

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- (a) The actual charge for the service; or
- (b) The usual and customary charge for that service by the carrier, as shown in the schedule of usual and customary charges submitted by the carrier to the department; or
- (c) The program maximum established for the service.
- (2) Program maximums shall be:
- (a) For nonambulatory recipients who require the use of a wheelchair, the upper limit shall be twenty-five (25) dollars for the first recipient plus four (4) dollars for each additional nonambulatory recipient transported on the same trip, for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollar and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and certified; mileage charges shall not be allowed for additional recipients.
- (b) For ambulatory recipients who are disoriented, the upper limit shall be twelve (12) dollars and fifty (50) cents for the first recipient plus four (4) dollars for each additional disoriented recipient transported on the same trip for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollars and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and verified; mileage charges shall not be allowed for additional recipients.
- (c) For both paragraphs (a) and (b) of this section, empty vehicle miles shall not be included when computing allowable reimbursement for mileage.
- (3) Reimbursement shall be made at specialty carrier rates for the following types of recipients only:
- (a) Nonambulatory recipients who need to be transported by wheelchair, but shall not include recipients who need to be transported as stretcher patients; and
- (b) Ambulatory recipients who are disoriented.

(4) The specialty carrier shall obtain a statement from the recipient's physician (or, if the recipient is in a nursing facility, from the director of nursing, charge nurse, or medical director in lieu of physician) to verify that transportation by the specialty carrier is medically necessary due to the recipient's nonambulatory or disoriented condition. Claims for payment which are submitted without the required statement of verification shall not be paid.

F. Specially authorized transportation services authorized in unforeseen circumstances may be paid for at a rate adequate to secure the necessary service; the amount allowed shall not exceed the usual and customary charge of the provider. The Department for Medicaid Services shall review and approve or disapprove requests for specially authorized transportation services based on medical necessity.

G. Use of flat rates.

Transportation payment shall not exceed the lesser of six (6) dollars per trip, one (1) way (or twelve (12) dollars for a round trip), or the usual fee for the participating transportation provider computed in the usual manner if:

- (1) The recipient chooses to use a medical provider outside the medical service area; and
- (2) The medical service is available in the recipient's medical service area; and
- (3) The recipient has not been appropriately referred by the medical provider within his medical service area.

H. Meals and Lodging.

The flat rate for meals and lodgings for recipients and attendants when preauthorized (or post-authorized if appropriate) by the department shall be as follows:

(1) Standard Area:

- (a) Meals: breakfast-\$4 per day; lunch-\$5 per day; dinner-\$11 per day; and
- (b) Lodgings: \$40 per day

(2) High Rate Area:

- (a) Meals: breakfast-\$5 per day; lunch-\$6 per day; dinner-\$15 per day; and
- (b) Lodgings: \$55 per day.

I. Limitations.

(1) Any reimbursement for medical transportation shall be contingent upon the recipient receiving the appropriate preauthorization or postauthorization for medical transportation as required by the Department for Medicaid Services.

(2) (a) Authorization shall not be granted for recipients transported for purposes other than to take the recipient to or from covered Medicaid services being provided to that recipient, except in the instance of one (1) parent accompanying a child to or from covered medical services being provided to the child or if one (1) attendant is authorized for a recipient traveling to or from covered medical services based on medical condition of the recipient.

(b) Reimbursement shall be limited to transportation services and shall not include the services, salary or time of the attendant or parent.

(3) An individual who owns a taxi company and who uses the taxi as his personal vehicle shall be reimbursed at the private auto rate when transporting household family members.

(4) Mileage for reimbursement purposes shall be computed by the most direct accessible route from point of pickup to point of delivery.

VIII. Outpatient Hospital Services

- A. Effective August 1, 2003, the Department will pay for in-state outpatient hospital services in accordance with the following:
1. Cardiac catheterizations, CT scans, lithotripsies, magnetic resonance imaging, ultrasounds, and observations will be paid at a fixed rate per procedure/service.
 - a. The rates for treatment procedures, including cardiac catheterization and lithotripsy, were calculated at 150% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.
 - b. The rates for diagnostic procedures, including CT scans, ultrasounds, and magnetic resonance imaging were calculated at 100% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.
 - c. The rate for observation was calculated at 100% of the average adjusted cost for state fiscal years 2000 and 2001.
 2. Outpatient services billed with the following revenue codes will be reimbursed on an interim basis by multiplying billed charges by a facility-specific outpatient cost-to-charge ratio:

Service	Revenue Code
Pharmacy	250,251,252,254,255,258,260,261, 634,635,636
X-Ray	320,321,322,323,324,330,342,400, 403,920
Supplies	270,271,272,274,275,621,622,623
EKG/ECG & Therapeutic Supplies	410,412,413,420,421,422,423,424, 440,441,442,443,460,470,471,472, 480,482,510,512,516,517,730,731, 732,740,901,922,940,942,943
Room & Miscellaneous	280,290,370,372,374,700,710,750, 761,890,891,892,893,921
Dialysis	821,831,841
Chemotherapy	330,331,332,333,334,335

- a. The cost-to-charge ratio is determined by dividing each hospital's Medicaid costs for providing outpatient services by its Medicaid outpatient billed charges. The cost and charge data will be taken from the most recently audited Medicare cost report.
 - b. Upon receipt of the audited cost report, payments will be settled to cost at the hospital-specific fiscal year-end.
3. If a service listed in the chart above is provided to the same recipient on the same day as a service listed under subsection 1, it will be included in the fixed rate per procedure.
 4. Outpatient surgeries will be grouped according to the 1997 Medicare ambulatory surgical center groups and paid at the following rates which are adjusted to reflect the higher costs associated with providing services in a hospital setting:

Ambulatory Surgical Center Group	Reimbursement Rate
Group 1	\$397
Group 2	\$534
Group 3	\$610
Group 4	\$753
Group 5	\$858
Group 6	\$1,016
Group 7	\$1,191
Group 8	\$1,191

Surgeries that do not have a group rate will be reimbursed at a facility-specific outpatient cost-to-charge ratio.

5. Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges, with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A. 1 through 4 will be bundled with the fixed rate payment and not reimbursed separately.

6. Emergency room services

- a. The Department will reimburse for emergency room services at a fixed rate per visit based upon the level of service provided. In addition, cardiac catheterization lab, CT Scan, lithotripsy, magnetic resonance imaging, observation, and ultrasound will be paid on a fixed rate basis in accordance with Section A(1).
- b. Services provided in the emergency room will be paid according to three (3) levels of service with a corresponding assessment fee as follows:
 - An assessment, or triage, shall be payable at \$20.00.
 - Level I will be those services billed using CPT code 99281, reimbursed at \$82.00.
 - Level II will be those services billed using CPT codes 99282 and 99283, reimbursed at \$164.00.
 - Level III will be those services billed using CPT codes 99284, 99285, 99291, and 99292, reimbursed at \$264.00.
- c. The flat rates per visit were calculated in accordance with the following:

The Level II rate was calculated by multiplying the average costs for Level II services in state fiscal years 2000 and 2001 (adjusted by the moving average of Data Resources, Inc., for the Hospital Market Basket) by .75.

The Level I rate was established at 50% of the Level II rate. The Level III rate was established at \$100 higher than the Level II rate.
- d. Services listed under Section A(2) will be bundled with the emergency room payment and will not be paid an additional amount. Additional reimbursement will be made for CT Scan, magnetic resonance imaging, observation, ultrasound, lithotripsy, and cardiac catheterization when provided with an emergency room visit at the fixed rate amount.
- e. Thrombolytic agents will be reimbursed at the hospital's acquisition cost.

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7. The Department will reimburse state-owned or operated hospitals on an interim basis in accordance with the above provisions with a settlement to actual Medicaid costs at the end of the year.

B. Critical Access Hospitals

1. Outpatient services in a critical access hospital will be exempt from the fixed rate reimbursement system and will be reimbursed on an interim basis by multiplying charges by the lesser of the Medicare cost-to-charge ratio or the Medicaid outpatient cost-to-charge ratio. This interim rate will be settled to cost at the end of the year.
2. Laboratory services provided in a critical access hospital will be reimbursed in accordance with the Medicare fee schedule and settled to cost at the end of the year.

C. Out of State Hospitals

1. Outpatient services which include cardiac catheterization lab, CT Scan, lithotripsy, magnetic resonance imaging, observation, ultrasound, and outpatient surgeries provided by an out-of-state hospital will be reimbursed in accordance with Section A.
2. Outpatient services listed in Section A(2) provided by an out-of-state hospital will be reimbursed by multiplying the average outpatient cost-to-charge ratio of in-state hospitals by the charges billed.

D. Cost Reports

In-state hospitals providing outpatient services will be required to submit a cost report within five (5) months after the hospital's fiscal year end.

- E. An emergency room or other outpatient service provided within 3 days of an admission for the same or related diagnosis will be included in the reimbursement for the inpatient admission and will be paid in accordance with Attachment 4.19-A.

State: Kentucky

F. Supplemental Payments to Non-state Government-owned or Operated Hospitals.

1. The Department provides quarterly supplemental payments to non-state government-owned or operated hospitals for outpatient services provided to Medicaid recipients. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.

2. To qualify for a supplemental payment, a hospital must be a non-state government-owned or operated hospital that has entered into an Intergovernmental Transfer Agreement with the Commonwealth. The payment amount for a qualifying hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

TN # 01-15
Supersedes
TN # None

Approval Date: FEB 12 2002 Effective Date: 4/02/01

G. Emergency Room Services

1. Effective for services provided on and after September 1, 2002, the Department will reimburse for emergency room services at a flat rate per visit based upon the level of service provided. In addition, diagnostic and radiological procedures will be paid at specific rates.
2. There shall be rates for three (3) levels of service and an assessment fee:
 - Level I shall be those services billed using CPT codes 99281 and 99282, reimbursed at \$82.00.
 - Level II shall be those services billed using CPT codes 99283 and 99284, reimbursed at \$164.00.
 - Level III shall be those services billed using CPT codes 99285, reimbursed at \$264.00
 - An assessment, or triage, shall be payable at \$20.00

Included in the flat rate are pharmacy (except for thrombolytic agents), medical supplies, radiology (except as described in 4 below), laboratory, physical and respiratory therapy, electrocardiogram, and electroencephalogram.

3. The flat rates per visit were calculated in accordance with the following:

The Level II rate was calculated by multiplying the average costs for Level II services in state fiscal years 2000 and 2001 (adjusted by the moving average of Data Resources, Inc. for the Hospital Market Basket) by .75.

The Level I rate is established at 50% of the Level II rate.
The Level III rate is established at \$100 higher than the Level II rate.
4. Separate rates were established for the following:

The rates for treatment procedures including cardiac catheterization and lithotripsy are calculated at 150% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

The rates for diagnostic procedures including CT scans, ultra sounds, and magnetic resonance imaging are calculated at 100% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

The rate for observation are calculated at 100% of the average adjusted costs for state fiscal years 2000 and 2001.
5. Thrombolytic agents shall be reimbursed at acquisition costs.

X. Home Health Agency Services

(1) The following home health services are paid in accordance with a fee schedule established by the state Medicaid agency, not to exceed billed charges:

Skilled Nursing
Home Health Aide
Medical Social Service
Physical, Occupational and Speech Therapy

(2) Enteral nutritional products and disposable medical supplies shall be reimbursed based on costs as submitted on an annual cost report. Providers shall be paid an interim rate determined by multiplying a provider's facility-specific cost to charge ratio by its billed charges. Interim payments shall not exceed submitted charges and will be settled back to actual cost at the end of the home health agency's fiscal year, subject to lower of costs or charges. Interim payments will be settled back to allowable cost within 18 months following the end of the agency's fiscal year. Allowable costs will be based on audited or desk reviewed cost reports and determined in accordance with Medicare reimbursement principles. Cost reports for each of the home health agencies described in sections (3), (4), and (5) must be received by the Department within five (5) months of the close of the agency's fiscal year (May 31).

Public providers will not be subject to the lower of cost or charges and will be reimbursed their total allowable cost for enteral nutritional and disposable medical supplies.

(3) Payment to a new home health agency for the services described in (1) will be in accordance with the methodology described in (1). New home health agencies will be paid for enteral nutritional products and disposable medical supplies on an interim basis by multiplying their billed charges for these products by seventy (70) percent. A new home health agency will be held to the seventy (70) percent threshold until a cost report is received by the state Medicaid agency. A home health agency that did not participate under the current ownership or a previous ownership in the prior year will be considered a new home health agency. A new home health agency will be reimbursed as described above until a cost report is received by the department, no later than May 31 prior to the rate year beginning July 1.

(4) Payment to an out of state home health agency for the services described in (1) will be in accordance with the methodology described in (1). Out of state agencies will be paid for enteral nutritional products and disposable medical supplies by multiplying billed charges by eighty (80) percent.

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- (5) For home health services provided by licensed county health department home health agencies, a supplemental payment which represents the difference between the estimated costs of home health services for the eight month period beginning November 1, 2002 and ending June 30, 2003 and the amount of payments made by the Department for these services under the flat fee reimbursement as describe in (1) will be made.

Using cost reports filed with the Department, the Department will calculate the unit cost for a service listed under (1) and compare the unit cost to the rate per unit as described in (1). The supplemental payment will equal the difference between the cost per unit of service multiplied by the number of units of service provided during the period. In this way, the Department shall assure public providers reimbursement for their total allowable costs.

If a provider's costs as estimated from the annual cost report are less than the estimated payments, the Department will recoup any excess payments.

- (6) Services provided by County Health Department Home Health Agencies. For the fiscal period beginning July 1, 2003 and for subsequent periods beginning July 1, supplemental payments will be made on a quarterly basis. The supplemental payments will be compared to the provider's annual cost report and adjustments made as described in (5) above.

XI. Laboratory Services

Eff. 7-1-88 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.

XII. (Deleted)

XIII. Family Planning Clinics

Eff. 7-1-87 The State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR Section 447.321; payments shall not exceed applicable Title XVIII upper limits. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall not exceed the 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		

XIV: Durable Medical Equipment, Supplies, Prosthetics and Orthotics

1. General DME Items

For DME items that have an HCPC code (except for customized items) reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

a. Customized items with a miscellaneous HCPC code of K0108 will require prior-authorization and will be reimbursed at invoice minus twenty-two (22) percent, not to exceed the supplier's usual and customary charge.

b. Customized components that do not have a HCPC code, and all other miscellaneous codes will require prior-authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary change.

c. DME items that do not have HCPC codes and have been determined by the department to be covered will require prior authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

d. Specialized wheelchair bases with codes of K0009 and K0014 will require prior authorization and will be reimbursed at manufacturers suggested retail price minus fifteen (15) percent, not to exceed the supplier's usual and customary charge.

TN No. 03-06
Supersedes
TN No. 01-05

Approval Date 007 31 2003 Effective Date 01-01-03

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers and primary care centers shall be reimbursed in accordance with the limitations in 42 CFR 447.325.

- A. Community mental health centers.
1. Prior to July 1, 2002, participating in-state mental health centers shall be reimbursed as follows:
 - a. The department shall establish final prospective rates for each direct service cost center using audited annual cost reports for the prior year. If an audited costs report is not available, the most recent unaudited cost report shall be used with the rate adjusted as necessary at the time of audit or desk review.
 - b. Costs used in setting the rates shall be trended to the beginning of the rate year and indexed for inflation using the Home Health Agency Market Basket National Forecast.
 - c. Direct service costs shall be arrayed and an upper limit set at 130 percent of the median cost per unit.
 - d. The base rate per unit shall be the allowable cost or the upper limit, whichever is less.
 - e. In addition to the base rate per unit, each center shall receive a cost savings incentive payment equal to fifteen (15) percent of the difference between the facility's allowable cost and the upper limit.
 - f. A funding adjustment equal to \$1.3 million shall be distributed based on the number of outpatient units of service provided. This adjustment is to improve services and to encourage the provision of additional services.
 - g. The reimbursable departmental cost centers are inpatient psychiatry, inpatient other, intensive in home, personal care, outpatient psychiatry, outpatient individual, outpatient group, and therapeutic rehabilitation.
 2. Participating out-of-state mental health center providers shall be reimbursed the lower of charges, or the facility's rate as set by the state Medicaid Program in the other state, or the upper limit for that type of service in effect for Kentucky providers.
 3. For state fiscal year July 1, 2002 - June 30, 2003, the payment rates for other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers will be the rates that were in effect on June 30, 2002. This payment shall not include any additional add-ons as described in 1.e and 1f. above.

- B. Effective for services provided on and after July 2, 2001, primary care centers will be reimbursed in accordance with the prospective payment system described in Attachment 4.19-B, page 20.16 for FQHCs and RHCs.

State Kentucky

Attachment 4.19-B
Page 20.15(b)

For drugs for specified immunizations provided free from the Health Department to primary care centers for immunizations for Medicaid recipients, the cost of the drugs are paid to the Health Department. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

Effective January 1, 1989, the cost for these immunizations will not be allowed as a part of the primary care center cost base so long as these drugs are available free from the Health Department.

TN # <u>89-30</u>	Approval	Effective
Supersedes	Date <u>OCT 16 1989</u>	Date <u>7-1-89</u>
TN # <u>None</u>		

Received 9/27/89

For the period 10/01/02 through 6/30/04, adjusted payments will be made to Community Mental Health Centers to recognize and support their continued commitment to the provision of mental health services. These payments will be made on a quarterly basis and will reflect the difference in the costs used to determine current rates and Medicaid Costs determined as follows:

1. Using audited cost reports ending June 30, 2000, costs for the covered mental health rehabilitation services described in Attachment 3.1- A, page 7.6.1(a) and Attachment 3.1-B, page 31.5(a) will be allocated to the following cost centers: therapeutic rehabilitation, outpatient individual, outpatient group, outpatient psychiatry, outpatient/personal care home, outpatient/in-home setting, and hospital psychiatric (professional services provided in an inpatient setting).
2. The Medicaid percentage for each cost center will be determined by dividing Medicaid units of service by total units of service by cost center.
3. Medicaid costs per cost center will be determined by multiplying costs by the Medicaid percentage per cost center.
4. Medicaid costs per cost center will be inflated to the mid-point of the rate year using the Home Health Market Basket Index.
5. The increased Medicaid capital will be determined by multiplying any capital increase from the base year to the rate year by the aggregate Medicaid percentage. The aggregate Medicaid percentage is determined by dividing total Medicaid costs by total costs.
6. The difference between the base year Medicaid costs and the inflated Medicaid costs will be added to the increased Medicaid capital.
7. Costs shall be determined in accordance with cost principles outlined in the Provider Manual. Only Medicaid recognized costs will be included in the calculation.
8. These adjusted payments will expire on July 1, 2004.

Payment methodology for rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and that are provided through an agreement with the State Health or Title V agency.

A. Rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rates for rehabilitative services are negotiated rates between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of each service.

The payment rate for rehabilitative services that are authorized after June 30, 2002, are uniform rates, determined by 98% of the weighted median of claims for each service for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

B. Rehabilitative services for children under the supervision of the state and that are provided through an agreement with the State Health or Title V agency.

Payments for rehabilitative services covered in Attachment 3.1-A, page 7.6.1 and Attachment 3.1B, page 31.5 for the target populations are per service. They are based upon one or more documented rehabilitative services provided to each client. The rates for the rehabilitative services are based upon the actual direct and indirect costs to the providers. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing rehabilitative services based on financial information submitted by the provider.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: identification, by recipient and worker, of each individual service provided, a showing of all direct costs for rehabilitative services; and a showing of all indirect costs for rehabilitative services appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principle if necessary.

Rehabilitative service providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

XVII. FQHC/RHC Services

Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) shall be made in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA).

For the period of January 1, 2001 through June 30, 2001, the state will implement an alternative reimbursement methodology that is agreed to by the state and the individual center/clinic and results in a payment rate to the center/clinic that is at least equal to the Medicaid PPS rate. The alternative methodology shall be in accordance with the state plan in effect on December 31, 2000.

All FQHCs and RHCs are reimbursed on a prospective payment system beginning with State Fiscal Year 2002 with respect to services furnished on or after July 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the clinic/center's reasonable cost for the clinic/center's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic/center's fiscal year 2001 and increased by an appropriate medical index. These costs are divided by the number of visits/encounters for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for state fiscal year 2002. For each state fiscal year thereafter, each clinic/center will be paid the amount (on a per visit basis) equal to the amount paid in the previous state fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that state fiscal year. The clinic/center must supply a budgeted cost report of the change in service to justify scope of service adjustments.

For newly qualified FQHCs/RHCs after State Fiscal Year 2001, initial payments are established by cost reporting methods. A newly qualified clinic/center shall submit a budgeted cost report from which an interim rate shall be established. After completion of a clinic/center fiscal year, a final PPS rate will be established. After the initial year, payment is set using the MEI methods used by other clinics/centers, with adjustments for increases or decreases in the scope of service furnished by the clinic/center during that fiscal year.

In the case of a FQHC or RHC that contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the center or clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the center or clinic is entitled under the PPS.

Until a prospective payment methodology is established, the state will reimburse FQHCs/RHCs based on the rate in effect on June 30, 2001. This rate is based on the State Plan in effect on June 30, 2001. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

State: Kentucky

XVIII. Outpatient Surgical Centers

The Department shall utilize the 1996 Medicare ambulatory surgical center group rates for the federal Cincinnati, Ohio-Kentucky region to reimburse for an outpatient surgical center service. Following is a chart which states the reimbursement rate for each corresponding surgical group:

ASC Group	Reimbursement Rate
Group 1	\$307.38
Group 2	\$412.79
Group 3	\$471.90
Group 4	\$582.25
Group 5	\$664.02
Group 6	\$775.59
Group 7	\$921.15
Group 8	\$911.55

Procedures that are not included in one (1) of the eight (8) Medicare surgical groups, reimbursement shall be on the basis of forty-five (45) percent of the center's usual and customary charge for the procedure performed. Payment rates shall not exceed the provider's usual and customary charge to the general public. Hospital based outpatient surgical centers shall be reimbursed in the same manner as hospital outpatient services.

XIX Nurse-Midwife Services

Participating nurse-midwife providers shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of the nurse-midwife.

For services provided on or after July 1, 1990, payments to nurse-midwives shall be at usual and customary actual billed charges on a procedure-by-procedure basis, with reimbursement for each procedure to be the lesser of the actual billed charge or at seventy-five (75) percent of the fixed upper limit per procedure for physicians.

TN # 90-30 Approval Date 10-17-90 Effective Date 7-1-90
Supersedes
TN # 90-13

XX. Nurse anesthetist services

Reimbursement will be made at the rate of seventy-five (75) percent of the anesthesiologist's allowable charge for the same procedure under the same conditions, or at actual billed charges if less.

Exception:

For inpatient delivery-related anesthesia services provided on or after December 1, 1988, a nurse anesthetist will be reimbursed the lesser of the actual billed charge or the standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Normal Delivery, \$150.00;
Low Cervical C-Section, \$202.50;
Classic C-Section, \$240.00;
Epidural Single, \$236.25;
Epidural Continuous, \$251.25;
C-Section with Hysterectomy, subtotal, \$240.00;
C-Section with Hysterectomy, total, \$240.00;
Extraperitoneal C-Section, \$240.00

TN # 88-22
Supersedes
TN # 83-19

Approved JAN 23 1989
Received 12/9/88

Effective
Date 12-1-88

XXI. Podiatry Services

The cabinet shall reimburse licensed, participating podiatrists for covered podiatry services rendered to eligible Medical Assistance recipients at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the cabinet at 65 percent of the median billed charge for outpatient services and 50 percent of the median billed charge for inpatient services using 1989 calendar year billed charges. If there is no median available for a procedure, or the cabinet determines that available data relating to the median for a procedure is unreliable, the cabinet shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. 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.

XXII. Hospice Care

A. General Reimbursement

Reimbursement for hospice care will be made at one of four predetermined rates for each day in which a recipient is under the care of the hospice. The daily rate is applicable to the type and intensity of services furnished to the recipient for that day. There are four levels of care into which each day of care is classified:

1. Routine Homecare
2. Continuous Homecare
3. Inpatient Respite Care
4. General Inpatient Care

The Medicaid hospice rates are set prospectively by Centers for Medicare and Medicaid Services, based on the methodology used in setting Medicare hospice rates and adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register.

B. Reimbursement for Room and Board

Hospice is reimbursed a per diem amount to cover room and board, for those recipients who reside in a nursing facility. The state shall reimburse ninety five percent (95%) of the nursing facility's Medicaid per diem to the hospice provider, to cover the expenses of the room and board provided to the hospice patient who occupies a Medicaid certified bed in a nursing facility.

The hospice provider shall have a contract with the nursing facility stipulating that:

1. Room and board shall be provided by the nursing facility for the hospice resident;
2. The rate the nursing facility will charge the hospice provider for room and board furnished to the Medicaid hospice resident; and
3. The hospice is fully responsible for the professional management of the Medicaid hospice patient's care.

C. Limitation on Payments for Inpatient Care

1. The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid patients not exceed twenty percent (20%) of the total days for which these patients have elected hospice.
2. At the end of the cap period, Medicaid will calculate a limitation on payment for inpatient care (general or respite) to ensure payment is not made in excess of twenty percent (20%) of the total number of days of hospice care furnished to Medicaid patients.
3. If the number of days of inpatient care furnished to Medicaid patients is equal to or less than twenty percent (20%) of the total days of hospice care to Medicaid patients, no adjustment is necessary. Overall payments to a hospice are subject to the cap amount.

D. Monitoring of Reimbursement

The Department for Medicaid Services will perform a desk audit on each hospice provider once a year following the end of the cap period in order to compute and apply the cap amount and audit payments made for inpatient services.

XXIII. Case Management Services

A. Targeted case management services for severely emotionally disturbed children and adults with chronic mental illness.

The Department will pay for a unit of targeted case management up to allowable reasonable cost per unit, not to exceed 130% of the median cost per unit of all providers. Reasonable costs shall be determined from the latest prior year audited cost reports. Total payments will not exceed provider's actual costs.

"Unit" is defined as a month. A unit consists of a minimum of four service contacts, for a child two of the contacts must be face-to-face, at least one with the child and the other with a parent or family member. The other contacts may be by telephone or face-to-face and may be with or on behalf of the child. For adults, four service contacts must also be made, two are required to be face-to-face.

The unit cost is based on audited prior fiscal year cost reports. Adult TCM and child TCM are separate cost centers. Cost per unit is determined by dividing the overall costs for the service by the number of units of service provided.

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 available free through the Vaccines for Children Program shall not be reimbursed.
- c. 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.

- d. Reimbursement for an anesthesia service provided during a procedure shall be inclusive of the following elements:
 - 1. Preoperative and post-operative visits;
 - 2. Administration of the anesthetic;
 - 3. Administration of intravenous fluids and blood or blood products incidental to the anesthesia or surgery;
 - 4. Post-operative pain management; and
 - 5. Monitoring services.

- e. Reimbursement of a psychiatric service provided by an ARNP shall be limited to four (4) psychiatric services per ARNP, per recipient, per twelve (12) months.

- f. Reimbursement for a laboratory service provided in an office setting shall be inclusive of:
 - 1. The fee for collecting and analyzing the specimen; and
 - 2. Should the test require an arterial puncture or venipuncture, the fee for the puncture.

- g. Reimbursement shall be limited to one (1) of the following evaluation and management services performed by an ARNP per recipient, per date of service:
 - 1. A consultation service;
 - 2. A critical care service;
 - 3. An emergency department evaluation and management service;
 - 4. A home evaluation and management service;
 - 5. A hospital inpatient evaluation and management service;
 - 6. A nursing facility service;
 - 7. An office or other outpatient evaluation and management service;
 - 8. A preventive medicine service; or
 - 9. A psychiatric or other psychotherapy service.

(Revised)

State Kentucky

Attachment 4.19-B
Page 20.33

XXVI: Federally Qualified Health Center Services

Enrolled Federally Qualified Health Center providers shall be paid full reasonable cost determined in the same manner as for primary care centers except that cost shall not include an incentive payment.

TN No. 90-11
Supersedes
TN No. None

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XXVIII, Public Health Clinics

- A. This methodology applies to services described on Attachments 3.1-A, pages 7.6.1, 7.6.1(c) – (e), and 3.1-B, pages 31.5, 31.5(c) – (e).
- B. Reimbursement
 - 1. Covered services shall be paid based on Medicare RVU adjusted by the current Medicare conversion factor for Kentucky, multiplied by non-facility relative value unit weight for the procedure code. These factors will be adjusted each January as adjusted by Medicare.
 - 2. If a copayment applies to the service, the reimbursement rate shall be reduced by the amount of the copayment.

XXIX Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

- (1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services), the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:
- (a) 1905(a)(1), inpatient hospital services;
 - (b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
 - (c) 1905(a)(3), other laboratory and X-ray services;
 - (d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
 - (e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
 - (f) 1905(a)(6), medical care by other licensed practitioners;
 - (g) 1905(a)(7), home health care services;
 - (h) 1905(a)(9), clinic services;
 - (i) 1905(a)(10), dental services;
 - (j) 1905(a)(11), physical therapy and related services;
 - (k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
 - (l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
 - (m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
 - (n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
 - (o) 1905(a)(17), nurse-midwife services;
 - (p) 1905(a)(18), hospice care;
 - (q) 1905(a)(19), case management services; and
 - (r) 1905(a)(22), other medical and remedial care specified by the Secretary.
- (2) For medically-necessary evaluative, diagnostic, preventive, and treatment services listed in Section 1905(a) of the Social Security Act included in an Individual Education Program under the provisions of the Individuals with Disabilities Education Act, the state shall pay in accordance with items (1) or (3), as applicable, except that for public providers the payment shall be a fee-for-service system designed to approximate cost in the aggregate without settlement to exact cost. The following describes the methodology utilized in arriving at the rates.

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- (a) The aggregate will be calculated for all participating public providers in the state. Initial interim rates will be established using data provided by the Department of Education from most of the public providers in the state and data gathered in surveys. During the first year, participating providers will be required to provide data which will be used to calculate final rates; claims paid using the interim rates will be adjusted after final rates have been established. This process will be repeated each state fiscal year as new providers are added and as previously participating providers experience changes with regard to their costs. Through this process, cost in the aggregate will only reflect the cost of participating providers on a statewide basis.
- (b) Payments to public providers are based on a statewide fee for each procedure code. A fee for a particular procedure code is based on the lower of the mean or median statewide cost of providing the service. The statewide mean and median cost to participating providers for a service is based on a 100 percent sample of the contracted service cost and/or cost associated with publicly employed professionals. Cost for publicly employed professionals consists of salary, fringe benefits and indirect overhead. Annual professional salaries are converted to hourly wages using 185 work days per year and six (6) work hours per day. For salaried employees the public provider fringe benefit rates for classified employees and for certified employees will be used. Indirect overhead cost computed at the rate of seven (7) percent of hourly wage salaries is added to the hourly wage rate and the fringe benefits to establish their hourly cost.
- (c) The mean and median hourly rate is calculated, for each class of qualified professionals, from an array of hourly cost data falling within one standard deviation of the mean. The resultant hourly rates are converted to fifteen (15) minute service units.
- (d) The following two (2) exceptions to usual cost reimbursement will be applicable: first, for emergency medical transportation, reimbursement will be based on the average cost per mile of pupil transportation calculated by the Kentucky Department of Education; and, second, for assistive technology, reimbursement will be based on the actual invoiced cost for the IEP authorized equipment. Transportation will be paid based on units of one (1) mile.
- (3) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21, the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100 percent of usual and customary

charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

- (a) Any service described in one (1), above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
- (b) 1905(a)(8), private duty nursing services;
- (c) 1905(a)(20), respiratory care services;
- (d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
- (e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitariums, and personal care services in a recipient's home.

Payment for EPSDT Special Service Limited by Medicaid

For the services listed above in section XXIX subsection (1), the department shall reimburse for an expanded EPSDT service based upon the established methodology for other similar services under the Kentucky Medicaid Program." The reimbursement of the expanded EPSDT service shall not exceed 100 percent of the usual and customary charges. If the benefit is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. If an expanded EPSDT service is provided before prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.

State Kentucky

XXX. Radiological (X-ray) Services

Payments for radiological services covered pursuant to the mandate contained in 42 CFR 440.30 shall be at usual and customary charges up to sixty (60) percent of the allowable physician fee for the same procedures where the physician is performing both the professional and technical portions of the service.

TN # 92-25
Supersedes
TN # None

Approved JAN 13 1993 Effective
Date 12-1-92

XXXI. Payment methodology for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and for adults in need of protective services.

A. Targeted case management services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rate for targeted case management is a negotiated rate between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of the service.

The payment rate for a targeted case management service that is authorized after June 30, 2002, is a uniform rate, determined by 98% of the weighted median of claims for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

The billable unit of service is one month

B. Targeted case management services for children under the supervision of the state and for adults in need of protective services.

Payments for targeted case management services for the target populations are monthly. They are based upon one or more documented targeted case management services provided to each client during that month. The monthly rate for the targeted case management services is based on the total average cost per client served by the provider. The monthly rate is established on a prospective basis based upon actual case management costs for the previous year. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing case management services based on financial information submitted by the provider.

Case management providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: directly coded worker time; identification, by recipient and worker, of each individual service provided, a showing of all direct costs for case management activities; and a showing of all indirect costs for case management activities appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principles if necessary.

XXXII. Specialized Children's Services Clinics

Clinic services provided by Specialized Children's Services Clinics will be reimbursed initially at a statewide uniform all-inclusive rate per visit (encounter rate) of \$538. This rate is estimated to approximate the average statewide costs of all clinics providing the service. This rate includes the costs of professional services (physician and mental health professional), related costs of providing a sexual abuse exam, and facility costs (overhead). This rate is based on the projected cost of providing the service as submitted to the department by the providers and a consideration of rates paid to providers for similar services.

Providers will submit cost reports annually. Upon receipt of completed cost reports from all clinics, the department will establish a rate within 90 days using updated cost data.

Payments made under this provision shall not exceed the upper limit of payment as specified in 42 CFR 447.325.

TN No. 01-07
Supersedes
TN No. None

Approval Date JAN 23 2002

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XXIII. Targeted Case Management and Diagnostic, Preventive and Rehabilitative Early Intervention Services for children eligible for the Early Intervention program provided through a Title V agreement.

This payment system is for all providers, including those providing services under the Title V agreement described in Supplement 1 to Attachment 4.16-A, Item #10.

All costs shall be determined based on the methodology outlined in OMB Circular A-87. Payments for case management, diagnostic, rehabilitative, and preventive early intervention services shall be made in accordance with a fee schedule established by the Title V agency. Interim payments shall be based on the direct cost of providing the service. Payments for overhead and administrative costs associated with providing the service shall be determined with a settlement to cost at the end of the fiscal year. Providers will submit cost reports no later than 180 days after the end of the state fiscal year.

XXXIV. Rehabilitation Services for Pregnant Women

Substance abuse services covered for pregnant women including postpartum women for a sixty (60) day period after the pregnancy ends and any remaining days in the month in which the 60th day falls, provided by any mental health centers, their subcontractors and any other qualified providers, licensed in accordance with applicable state laws and regulations. Payment for these services will be based on cost in accordance with attachment 4.19-B, pages 20.15-20.15.5.

Reimbursement for services shall be based on the following units of service:

Universal prevention service shall be a one-quarter (1/4) hour unit;
Selective prevention service shall be a one-quarter (1/4) hour unit;
Indicated prevention service shall be a one-quarter (1/4) hour unit;
Outpatient service shall be a one-quarter (1/4) hour unit for the following modalities:

Individual therapy;
Group therapy;
Family therapy;
Psychiatric evaluation;
Psychological testing;
Medication management; and
Collateral care;

An assessment service shall be a one-quarter (1/4) hour outpatient unit;
Day rehabilitation services shall be a one (1) hour unit;
Case management services shall be a one-quarter (1/4) hour unit; and
Community support shall be a one-quarter (1/4) hour unit;

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 physician's 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 chiropractors' services shall be based on the chiropractors' 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 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 chiropractors' usual and customary actual billed charges up to 125 percent of the fixed upper limit per procedure established by the Department.

(3) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the chiropractor'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.

D. Assurances. The state hereby assures that (1) payment for chiropractor services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances (42 CFR 447.325).

Targeted case management services for at risk parents during the prenatal period and until the child's third birthday

This payment system is for all providers, including those providing services under the Title V agreement described in Attachment 4.16-A, Item #10.

Payments shall be based on cost. Interim rates based on projected cost shall be used with a settlement to cost at the end of the state fiscal year. Case management providers who are public state agencies shall have on file an approved cost allocation plan.

Interim rates shall be established in the following manner:

- 1) The rate for the assessment shall be based on the projected cost of providing the service consistent with methodology in OMB Circular A-87. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.
- 2) The rate for the professional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.
- 3) The rate for the family service worker/paraprofessional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

Cost will be accounted for as follows:

- 1) Case management staff directly related to the targeted case management program will code all direct time using categories designated for case management functions in 15 minute increments.
- 2) Any contract costs (i.e., for contracted services) will be based on the actual cost of acquisition of the service.
- 3) Any indirect costs of any public state agency will be determined using the appropriate cost allocation plan.

Providers will submit cost reports no later than 180 days after the end of the state fiscal year. Interim payments will be adjusted to actual cost based upon review and acceptance of these cost reports in accordance with usual agency procedures.

Revision: HCFA-PM-91-4 (BPD)
August 1991

SUPPLEMENT 1 TO ATTACHMENT 4.19-B
Page 3

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT

State: Kentucky

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

- B. Medicaid payment for specified Medicare crossover claims will be the lower of the allowed Medicaid payment rates or the Medicare coinsurance and deductibles.
1. The specified Medicare Part A crossover claims are defined as: Inpatient Hospital and Nursing Facilities (effective 9/01/02).
 2. The specified Medicare Part B claims are defined as:
 - a. Physician services, Community Mental Health Center services, Advanced registered nurse practitioner services, podiatry services, chiropractic services, dental services, hearing and vision services, and laboratory and x-ray services (effective 2/01/03);
 - b. Durable Medical Equipment and Pharmacy (effective 4/01/03);
 - c. Emergency ambulance services (effective 6/01/03); and
 - d. Ancillary Services/Nursing Facilities (effective 11/01/03).

In the event that Medicaid does not have a price for codes included on a crossover claim the Medicare coinsurance and deductible will be paid.