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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

August 1, 2011

Mr. Neville Wise, Acting Commissioner
Cabinet for Health and Family Services
Departmart for Mediciad Services
275 E. Main Street, 6W-A
Frankfort, KY 40621

Re: Kentucky Title XIX State Plan Amendment, Transmittal #11-006

Dear Mr. Wise:

We have reviewed Kentucky State Plan Amendment (SPA) 11-006, which was submitted to the Atlanta Regional Office on July 6, 2011 in response to a companion letter that was issued for Kentucky SPA 11-003. This amendment removes the phrases "up to" and "not to exceed" from specified pages of the Kentucky State Plan.

Based on the information provided, we are now ready to approve Kentucky SPA 11-006 as of July 29, 2011. The effective date is July 1, 2011. The signed CMS-179 and the approved plan pages are enclosed. If you have any questions regarding this amendment, please contact Darlene Noonan at (404) 562-2707.

Sincerely,

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

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-006

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2011

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

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

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

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

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

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

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

SAME

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

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Neville Wise

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: March 23, 2011

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
07/29/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

IV. Vision Care Services

A. Definitions.

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

B. Reimbursement for Covered Procedures and Materials for Optometrists.

(1) Reimbursement for covered services, within the optometrist's scope of licensure, except materials and laboratory services shall be based on the lesser of the optometrists' usual and customary actual billed charges or the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS) with a conversion factor of $29.67.

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

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

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

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

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

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

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

D Effect of Third Party Liability

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

II. Physician Services

A. Definitions

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

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

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

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

(4) Reimbursement for an anesthesia service shall include:

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

B. Reimbursement

(1) Payment for covered physicians' services shall be based on the lesser of the physicians' usual and customary actual billed charges or the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS).

(2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit by reimbursing 45% of billed charges. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

(5) For services provided on or after July 1, 1990, family practice physicians practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the lesser of the physicians' usual and customary actual billed charges or 125 percent of the fixed upper limit per procedure established by the Department.

(6) For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the Medicare allowable payment rates. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

(7) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the physician's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

(8) Payments for the injection procedure for chemonucleolysis of invertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or at a fixed upper limit of $793.50 as established by the Department.

(9) Specified family planning procedures performed in the physician office setting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS fee plus actual cost of the supply minus ten percent.

(10) Certain injectable anitbiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.

(11) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).

(12) For practice related service provided by a physician assistant, the participating physician shall be reimbursed at the lesser of the usual and customary actual billed charge or the fixed upper limit per procedure established by the Department for Medicaid Services at seventy-five (75) percent of the physician's fixed upper limit per procedure.

(13) Any physician participating in the lock-in program will be paid a $10.00 per month lock-in fee for provision of patient management services for each recipient locked in to that physician.

XXXV Chiropractic Services

A. Definitions

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

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

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

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

B. Reimbursement

(1) Payment for covered chiropractor's services shall be based on the lesser of the chiropractor's usual and customary actual billed charges or the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS).

(2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein. RBRVS units shall be multiplied by the Non-anesthesia Related Services dollar conversion factor of $29.67 to arrive at the fixed upper limit.

C. Reimbursement Exceptions.

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

(2) For services provided on or after July 1, 1990, chiropractors practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the lesser of the chiropractors' usual and customary actual billed charges or up to 125 percent of the fixed upper limit per procedure established by the Department.