

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised:

February 1, 2002

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3. Laboratory and X-ray Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum is 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

(1) Clinical Laboratory Services

**Effective for dates of service occurring February 1, 2002 and after, clinical lab services as identified by the Medicare Clinical Lab Fee Schedule, will be reimbursed at the lesser of the 2001 Medicare rate or the amount billed.**

**At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at mutually acceptable increases or decreases from the maximum rates. Market forces, such as Medicare and private insurance rates, medical and general inflation figures, changes in service=s costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increases or decreases will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.**

**Codes deleted from future Medicare Clinical Lab Fee Schedules will also be removed from Medicaid reimbursable services. New codes added to the annual Medicare Clinical Lab Fee Schedule will be implemented at the current Medicare Clinical Lab Fee Schedule rate.**

(2) Portable X-ray Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum is 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal year, July 1, with any appropriate State Plan changes.

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3. Laboratory and X-ray Services

(3) Chiropractor X-ray Services

Effective for dates of service on or after June 1, 1998, the Arkansas Medicaid maximum for an X-ray will be calculated by using the average of the 1997 Medicare Physician=s Fee Schedule (participating fee) rates at 100% for the complete components for procedure codes 72010, 72040, 72050, 72070, 72100 and 72110; or such procedure codes implemented by Medicare, as the AMA (or it=s successor) shall declare are the replacements for, and successor=s thereto. The average rate will be established as the Medicaid maximum for procedure code Z1928 (Chiropractic X-ray), or such procedure code implemented by Arkansas Medicaid for the purpose of billing a Chiropractic X-ray.

Effective for dates of service on or after July 1 of each year, Arkansas Medicaid will apply an adjustment factor to the Medicaid maximum. To determine the adjustment factor a comparison between the previous and current year=s Medicare rates will be made. The adjustment factor will be equal to the average adjustment made to the Medicare payment rates, for all of the above CPT radiology procedure codes, as reflected in the current Medicare Physician=s Fee Schedule.

4.a. Nursing Facility Services (other than services in an institution for mental diseases) for individuals 21 Years of Age or Older - SEE ATTACHMENT 4.19-D

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

(1) Reimbursement for Child Health Services (EPSDT) is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum.