

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

Revised:

April 1, 2004

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

(3) Child Health Management Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum was established utilizing 80% of the Blue Shield customary as reflected in their 10/90 publication.

For those procedures which Blue Shield did not have a comparable code, the rates were increased by 35%. The 35% represents the average overall increase for all services.

Some procedure codes are reimbursed from the Rehabilitative Services for Persons with Mental Illness (RSPMI) fee schedule. The fee schedule for RSPMI was calculated based on 1978 cost data. A 20 percent inflation factor was applied to arrive at the "fee schedule" rate. Effective for dates of service on or after July 1, 1991, the RSPMI fee schedule was increased by another 20 percent.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

Effective for claims with dates of service on or after October 1, 1994, the Title XIX (Medicaid) maximum rates are the same maximum rates that were in effect before the July 1, 1992 twenty percent reduction.

For CPT-4 procedure codes 90804, 90805, 90806 and 90807, **reimbursement rates (payments) shall be the same as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.**

Effective for dates of service on or after March 1, 2000, the CHMS cap will no longer be imposed for procedure codes 99211, 99212, Z1570, Z1571, Z1572 and Z1575.

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

(10) Hearing Aid Dealers

Hearing aid vendors are reimbursed at 68% of retail price. Maintenance and repairs are reimbursed according to the lesser of the amount billed not to exceed a maximum of \$100.00 per repair/maintenance.

(11) Audiologist Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be the same as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

(12) Hearing Aids

Reimbursement based on 68% of retail price.

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

(18) Dental Services

- (a) Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.

For the following procedure codes, the Medicaid maximums were calculated using 80% of the 1992 Blue Shield Fee Schedule. Physician procedure codes utilized by dentists are reimbursed at 100% of the Medicare Physician Fee Schedule (Participating Fee) in effect at the beginning of the State Fiscal Year:

00471	07630
01525	07640
02710	07740
04220	09230

For the remaining preventive and restorative procedures, the Medicaid maximum was calculated using 95% of the 1997 Arkansas Blue Shield Dental Fee Schedule.

Orthodontia procedures are reimbursed at 70% of the 1995 Delta Dental Fee Schedule.

- (b) Oral Surgeons

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be the same as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

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4.c. Family Planning Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be the same as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

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5. Physicians' Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

Payment is made directly to the physician or, upon request of the physician, payment is made under the Deferred Compensation Plan.

Reimbursement for physicians' services for heart, liver, bone marrow, single lung and skin transplants is included in the \$150,000 maximum as described in Attachment 4.19-A, page 3, of the State Plan. Procedures will be manually priced based on professional medical review. The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

Participation in the Deferred Compensation Plan by a physician is entirely voluntary. The individual physician's authorization and consent is on file. The physician submits his claim in the usual manner, and after verification, the appropriate amount due the physician is deposited in an account administered by First Variable Life Insurance Company or The Variable Annuity Life Insurance Company up to the maximum amounts allowed by the Revenue Act of 1978. Each account in the investment funds is individualized as to each physician participating. Arkansas Division of Economic and Medical Services has no responsibility for management or investment of these funds. Federal matching is not claimed for any part of the administration of the Plan. This is a service designed to increase the number of participating physicians in the Medical Assistance Program.

Desensitization injections - Refer to Attachment 4.19-B, 4.b. (15).

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6. Medical Care and any other type of remedial care recognized under State Law, furnished by licensed practitioners with the scope of their practice as defined by State Law.
 - a. Podiatrists' Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be the same as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)
- d. Eyeglasses
- Negotiated statewide contract bid.
13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)
- a. Diagnostic Services - Not provided.
- b. Screening Services - Not provided.
- c. Preventive Services - Not provided.
- d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable.

The Title XIX maximum was established based on a survey by the Division of Mental Health of the usual and customary charges used by community based programs. Rates include the professional and administrative components.

For acute outpatient services and acute day treatment previously found in the Mental Health Clinic option, reimbursement is based on the lower of: (a) the provider's actual charge for the services or (b) the allowable fee from the State's fee schedule based on average cost. The average cost of each mental health service was calculated based on 1978 cost data. A 20 per cent inflation factor was applied to arrive at the fee schedule rate.

Effective April 1, 1988, reimbursement rates were increased 78% to reflect rates comparable to those charges found in the private sector for comparable mental health services. Effective July 1, 1991, a 20% increase was applied.

Effective for dates of service on or after December 1, 2001, reimbursement **rates (payments)** for inpatient visits in acute care hospitals by board certified psychiatrists **shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.**

Effective for claims with dates of service on or after March 1, 2002, Arkansas State Operated Teaching Hospital psychiatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The lesser of reasonable costs or customary charges will be used to establish cost settlements.

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16. Inpatient Psychiatric Facility Services For Individuals Under 22 Years of Age (Continued)

Sexual Offender Programs (continued)

New providers are required to submit a full year=s annual budget for the current State Fiscal Year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the upper limit (cap).

Year end cost reports must be submitted and will be audited in the same manner as audits for inpatient psychiatric hospital Residential Treatment Units (RTUs) and will be cost settled.

Interim rates and cost settlements are calculated using the same methodology as inpatient residential treatment units with the same professional component cap and the same annual State Fiscal year per diem cap.

17. Nurse Midwife Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum. The Title Maximum for nurse-midwife services is based on 80% of the current physician Medicaid Maximum. Rhogam RhoD Immune Globulin is reimbursed at the same rate as the physician's rate since the cost and administration of the drug does not vary between the nurse midwife and physician.

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3. Laboratory, X-ray Services and Other Tests

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. For hospital reimbursement for outpatient technical related services, the Title XIX (Medicaid) maximum is 66% of the Physician's Blue Cross/Blue Shield Schedule dated October 1, 1993. For other services and provider groups, reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds subject to any other specific State Plan reimbursement requirements (Examples – *Clinical Laboratory Services are reimbursed using a separate methodology. *The nurse practitioner is reimbursed 80% of the physician rate for some identified services).

(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. For hospital reimbursement for outpatient technical related services, the Title XIX (Medicaid) maximum is 66% of the Physician's Blue Cross/Blue Shield Schedule dated October 1, 1993. For other services and provider groups, reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds subject to any other specific State Plan reimbursement requirements (Examples – *Clinical Laboratory Services are reimbursed using a separate methodology. *The nurse practitioner is reimbursed 80% of the physician rate for some identified services).