

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

Revised: April 1, 2004

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 outpatient providers, reimbursement rates for services with a technical component are set at 66% of the Arkansas Physician's Blue Cross/Blue Shield (BC/BS) Fee Schedule dated October 1, 1993.

When medical professionals provide a service that is linked to a service with a technical component, 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).

For dates of service occurring July 1, 1994 through March 31, 2004, reimbursement rates are set at 66% of the Arkansas Physician's Blue Cross/Blue Shield (BC/BS) Fee Schedule dated October 1, 1993.

For dates of service occurring April 1, 2004 and after:

- A. Reimbursement rates are increased by 10% up to a maximum or benchmark rate of 80% of the 2003 Arkansas Blue Cross/Blue Shield (BC/BS) fee schedule. For rates that as of March 31, 2004, are equal to or greater than 80% of the 2003 BC/BS fee schedule rate, no increase will be given. A minimum rate or floor amount of 45% of the 2003 BC/BS fee schedule rate will be reimbursed. For those rates that after the 10 % increase is applied are still less than the floor amount, an additional increase will be given to bring these rates up to the floor amount.
- B. Reimbursement rate maximums are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.
- C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:
 - (1) **Increases:** If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is 30% of the combined rate then 30% of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.

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

Revised: April 1, 2004

3. Laboratory, X-ray Services and Other Tests (continued)

(2) **Decreases: If one component rate is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.**

(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

The Title XIX (Medicaid) maximum for portable X-ray services 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. Refer to Attachment 4.19-B, Item 3, for X-ray services reimbursement for physicians and other licensed practitioners.

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 rate, 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.

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

Revised:

April 1, 2004

3. **Laboratory and X-ray Services and Other Tests (Continued)**

(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.**

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)

(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. The Title XIX (Medicaid) maximum for audiology services is 100% of the current physician Medicaid maximum.

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 rate, 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.

(12) Hearing Aids

Reimbursement based on 68% of retail price.

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)

(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 as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

For dates of service occurring July 1, 1994 through March 31, 2004, reimbursement rates are set at 66% of the Arkansas Physician's Blue Cross/Blue Shield (BC/BS) Fee Schedule dated October 1, 1993.

For dates of service occurring April 1, 2004 and after:

- A. Reimbursement rates are increased by 10% up to a maximum or benchmark rate of 80% of the 2003 Arkansas Blue Cross/Blue Shield (BC/BS) fee schedule. For rates that as of March 31, 2004, are equal to or greater than 80% of the 2003 BC/BS fee schedule rate, no increase will be given. A minimum rate or floor amount of 45% of the 2003 BC/BS fee schedule rate will be reimbursed. For those rates that after the 10 % increase is applied are still less than the floor amount, an additional increase will be given to bring these rates up to the floor amount.**

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)

- B. Reimbursement rates are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.**
- C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:**

 - (1) Increases: If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is 30% of the combined rate then 30% of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.**
 - (2) Decreases: If one component rate, either technical or professional, is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.**

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

Revised: April 1, 2004

4.c. Family Planning Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum for Family Planning services is 100% of the current physician Medicaid maximum.

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 rate, 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.

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

Revised: April 1, 2004

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.

For dates of service occurring July 1, 1994 through March 31, 2004, reimbursement rates are set at 66% of the Arkansas Physician's Blue Cross/Blue Shield (BC/BS) Fee Schedule dated October 1, 1993.

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- B. Reimbursement rates are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.
- C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:
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 - (2) **Decreases:** If one component rate, either technical or professional, is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.

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

Revised: April 1, 2004

5. Physicians' Services (continued)

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 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).

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

Revised: April 1, 2004

5. Physicians' Services (continued)

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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 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).

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

Revised: April 1, 2004

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 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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B. Reimbursement rates are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.

C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:

(1) Increases: If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is 30% of the combined rate then 30% of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.

(2) Decreases: If one component rate, either technical or professional, is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.

Additional Reimbursement for Podiatrist's Services Associated with UAMS

Refer to Attachment 4.19-B, item 5.

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

Revised: April 1, 2004

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 for inpatient visits in acute care hospitals by board certified psychiatrists is based on 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

Effective for dates of service on or after April 1, 2004, reimbursement rates (payments) for inpatient visits in acute care hospital 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. Refer to Attachment 4.19-B, Item 5, for physician reimbursement.

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. **Medical professionals affiliated with UAMS are not eligible for additional reimbursement for services**

provided in these clinics.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-B
Page 6a

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

Revised: April 1, 2004

2. 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 XIX Maximum for nurse-midwife services is 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.

- (a) Additional Reimbursement for Nurse-Midwife Services Associated with UAMS – Refer to Attachment 4.19-B, item 5.