
Table of Contents

State/Territory Name: Kentucky

State Plan Amendment (SPA) #: 13-014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 6, 2013

Lawrence Kissner, Commissioner
Department for Medicaid Services
Attn: Karen Martin
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Dear Mr. Kissner:

We have reviewed the proposed Kentucky State Plan Amendment 13-014, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on October 1, 2013. SPA 13-014 establishes allergy testing, shots, and treatment for adults under the Physician Services benefit.

Based on the information provided, the Medicaid State Plan Amendment KY 13-014 was approved on December 5, 2013. The effective date of this amendment is January 1, 2014. Enclosed is the approved HCFA-179 and a copy of the new state plan pages.

A companion letter is also being issued with this approval to address the reimbursement concerns that developed during the corresponding financial review of this SPA.

If you have any additional questions or need further assistance, please contact Alice Hogan at (404) 562-7432 or Alice.Hogan@cms.hhs.gov.

Sincerely,

/s/

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

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, GA 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 6, 2013

Lawrence Kissner, Commissioner
Department for Medicaid Services
Attn: Karen Martin
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Dear Mr. Kissner:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) transmittal KY-13-014, which was submitted to establish benefits for allergy testing and injections for adults. Our review of KY-13-014 included a corresponding review of the reimbursement methodology for Physician Services, the benefit under which these services are provided. Based on that review, it was determined that the reimbursement methodology for Physician Services is not consistent with the Medicaid statutory and regulatory requirements described below. While we are proceeding with the approval of Kentucky SPA 13-014, this letter follows up on these matters as we want to work with you to resolve these issues.

Statutory and Regulatory Requirements

Section 1902(a) of the Social Security Act (the Act) requires that states have a state plan for medical assistance that meets certain federal requirements that set out a framework for the state program.

Section 1902(a)(30)(A) of the Act requires that states have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy, and quality of care. To be comprehensive, payment methodologies should be understandable, clear, and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

42 CFR 430.10 requires that the state plan be a comprehensive written statement that describes the nature and scope of the state's Medicaid program and that it contain all information necessary for CMS to determine whether the plan can be approved to serve as the basis for federal financial participation (FFP) in the state program.

1. Attachment 4.19 –B, page 20.3, B. (1)

   This paragraph currently reads, "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)."

   This language, as written, does not meet comprehensiveness requirements of 42 CFR 430.10 in that it does not provide enough information to determine the actual reimbursement rate. Since the state is reimbursing based on a fee schedule, please include the following effective date fee schedule language:

   "The agency's rates were set as of (insert date here) and are effective for services on or after that date. All rates are published (ex. on the agency's website). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers."

2. Attachment 4.19 –B, page 20.3, B. (2)

   This paragraph currently reads, "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."

   a. CMS normally does not consider reimbursement of charges a comprehensive payment methodology because charges vary by provider. Please provide definitive physician fee schedule language with effective date language.
   b. What is meant by a "fixed upper limit"?
   c. Please identify what is meant by "other factors."

3. Attachment 4.19-B, page 20.3(a) (4)

   This paragraph currently reads, "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."

   a. It is unclear as to whether the state is reimbursing this service based on a fee schedule. Please explain.
   b. Have the rates of payment for anesthesia services been recently reviewed to ensure adequacy of coverage?

4. Attachment 4.19-B, page 20.3(a), C. (2)

   Have the rates for obstetrical delivery services been recently reviewed to ensure adequacy of coverage?

5. Attachment 4.19-B, Page 20.4, (5)

   This paragraph currently reads, "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 billed charges **up to** 125 percent of the fixed upper limit per procedure established by the Department."

   For the payment methodology to be comprehensive, the state needs to delete the term "up to" and replace it with "or" and explain what is meant by "fixed upper limit."

6. Attachment 4.19 –B, page 20.4, (6)

   This paragraph currently reads, "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."

   a. The payment method for physician laboratory services should be under clinical diagnostic lab services.

   b. Please confirm that payment for laboratory services does not exceed the cost of Medicare on a per test basis.

   c. Since the state is reimbursing based on the Medicare fee schedule, please include effective date language identified in #1, above.

7. Attachment 4.19-B, page 20.4, (7)

   This paragraph currently reads, "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."

   Please specify what the alternative sites and/or setting are for physician payment. How is the payment defined by the site of service?

8. Attachment 4.19-B, page 20.4, (8)

   This paragraph currently reads, "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."

   To be clear, the language for payment of this injection procedure should be "...at the lesser of the actual billed charge, **or** $793.50."

9. Attachment 4.19-B, page 20.4, (9)

   This paragraph currently reads, "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."

   To meet comprehensiveness requirements, please include the effective date fee schedule language, identified in #1, for reimbursement for family planning procedures.

10. Attachment 4.19-B, page 20.4, (12)

    Please confirm if the following language is a correct understanding of the state's payment for physician assistant services: "For practice related service provided by a physician assistant, the participating physician shall be reimbursed at the lesser of the usual and customary charges actual billed charges or 75 percent of the physician's fixed upper limit per procedure." If so, please change.

11. Attachment 4.19-B Page 20.5, (15)

    This paragraph currently reads, "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".

    Please include the effective date fee schedule language identified in #1, above.

12. Attachment 4.19-B, Page 20.5, (16)

    Please confirm if the following language is a correct understanding of the state's payment for a bilateral procedure: "A bilateral procedure shall be reimbursed at one hundred fifty (150) percent of the Physician Fee Schedule." If so, please change.

13. Attachment 4.19-B, page 20.5, (22)

    This paragraph currently reads, "The evaluation and management services with a corresponding CPT code 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."

Is the payment for E&M services with the corresponding CPT codes at the current Medicare rate? Please clarify.

Please respond to this letter within 90 days of the date of the letter with a State plan amendment that addresses the issues described above or a corrective action plan describing how you will resolve the issues identified above. During the 90-day period, we are happy to provide any technical assistance that you need. State plans that are not in compliance with requirements referenced above are grounds for initiating a formal compliance process.

If you have any questions or need any further assistance, please contact Darlene Noonan at (404) 562-2707.

Sincerely,

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

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: 13-014

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
Effective January 1, 2014

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:
Affordable Care Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $1,074,000
b. FFY 2015 $1,433,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 3.1-A, Page 7.2.1(a)(o)
Att. 3.1-B, Page 22.1(a)

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

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment is to establish allergy testing and injections for adults

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: Lawrence Kissner

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 10/1/13

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
10-01-13

18. DATE APPROVED: 12-05-13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01-01-14

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

J. Reimbursement for induced abortions is provided when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.

L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.

M. Epidural or spinal injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.

N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

O. Coverage for an evaluation and assessment service, provided by a physician or physician assistant with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per calendar year.

1. The evaluation and assessment service shall be:
   a. Performed face-to-face with the recipient;
   b. Be performed over a period of at least ten (10) minutes.

2. The evaluation and assessment service shall include:
   a. Asking the recipient about tobacco use;
   b. Advising the recipient to quit using tobacco;
   c. Assessing the recipient's readiness to quit using tobacco products
   d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
   e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
   f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.

P. Allergy testing, shots and allergy treatment for all Medicaid recipients, when medically necessary.

J. Reimbursement for induced abortions is provided when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

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