
A. OUTPATIENT HOSPITAL AND OTHER SERVICES

1. Except for emergency room, lithotripsy, Federally Qualified Health Centers, laboratory and radiology services, the payment level for outpatient hospital claims will be based on 77% allowed charges for urban hospitals and 93% allowed charges for rural hospitals.
2. Payments for emergency room services vary depending on urban/rural designation and whether the service is designed as “emergency” or “non-emergency.” The “emergency” designation is based on the principal diagnosis (ICD-9 Codes). Rural hospitals will receive 98% of charges for emergency services and 65% for non-emergency use of the emergency room. Urban hospitals will receive 98% of charges for emergencies and 40% of charges for non-emergency use of the emergency room.
3. Payment for lithotripsy services is a fixed fee of \$2,800. The \$2,800 fee is all-inclusive except for physician services that are billed on the HCFA-1500. The rate includes all services related to lithotripsy for 90 days. No additional payment will be made for repeat procedures within the 90-day period. Treatment of the kidney on the opposite side will be paid as a separate treatment, but is also subject to the 90-day restriction. The payment rate will be reviewed and updated annually using economic trends and conditions.
4. Payment for laboratory and radiology services provided in a hospital to outpatients will be made based on HCPCS codes and an established fee schedule, unless a lesser amount is billed. The fee schedule used to pay physicians is used to establish payment rates.
5. Billed charges shall not exceed the usual and customary charge to private pay patients.
6. Payments for all outpatient services are limited to the aggregate annual amount Medicare would pay for the same services as required by 42 CFR 447.321.
7. Payments for physical therapy/occupational therapy are based on the established fee schedule unless a lower amount is billed. Fees are established by discounting historical charge, by professional judgement, and by the physical therapy and occupational therapy fee schedule. Since the amount of physical therapy and occupational therapy is limited, the select case management committee of the facility will determine which type of service (physical therapy or occupational therapy) should be provided for the patient by the facility. The amount of physical therapy provided will affect the amount of occupational therapy available, and vice versa.
8. Payment for partially completed services billed with a Modifier “73” shall be paid at 50% of the regularly schedule payment rate. This is to allow for the payment for the services that were rendered yet not completed due to a physician decision or for any other reason. This modifier is attached to the list of physician modifiers as per Attachment 4.19-B, Section D(6), Physicians special modifiers.

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Effective Date 1-1-05

A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

Beginning February 3, 2004, FQHCs may elect to be paid under one of two payment methods—the Prospective Payment Method (PPS) or the Alternative Payment Method (APM). Each FQHC must elect its payment methodology preference and give notice to the Division of Health Care Financing (DHCF) on or before January 1, 2004, to be effective February 3, 2004. If an FQHC elects to change payment methods in subsequent years, an election to do so must be made no later than thirty (30) days prior to the beginning of the FQHC's fiscal year by written notice to (DHCF).

a. Prospective Payment System (PPS).

1. Payment under PPS methodology conforms to the Federal methodology as contained in section 702 of the Benefits Improvement and Protection Act of 2001. PPS is the only approved methodology for the time period January 1, 2001 thru February 2, 2004, under the State Plan in effect for that time period.
2. PPS rates for each FQHC are determined on the basis of their 1999 and 2000 fiscal years' reasonable costs, adjusted for any subsequent change in scope of services (See Section A.9.c). The average of the two-year costs are divided by the average number of visits (physician services as defined by the State Plan, Attachment 3.1-A, Attachment #5) for the same two-year period. The resulting prospective rate is increased on January 1 of each subsequent year by the applicable Medicare Economic Index for primary care services.
3. Regarding FQHCs which contract with Managed Care Organizations (MCOs), supplemental payments will be estimated and paid quarterly to the FQHCs for the difference between amounts paid by the MCOs and amounts the FQHCs are entitled to under the PPS. Quarterly interim payments will be made no later than thirty (30) days after the end of the quarter. Annual reconciliations will be made and settled.
4. Mental Health (MH) services require FQHCs to contract with local MH providers that are paid a capitation rate by DHCF to avoid duplicate payments. FQHC MH charges are billed to MH providers which reimburse FQHCs on the basis of the MH provider fee schedule. The difference between FQHC MH cost and MH provider payments are reimbursed by DHCF as noted in section A.9.d.
5. The PPS rate for newly qualified FQHCs in 2001 and later will be established by reference to PPS rates of other FQHCs in the same or adjacent areas with similar caseload, or by cost reporting methods.

Supersedes T.N. # 04-003

Effective Date 1-1-05

A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) (Continued)

(6) FQHCs located out-of-state that serve Utah Medicaid clients will be paid the reimbursement rate applicable to the state in which services are provided.

b. Alternative Payment Method (APM)–Ratio of Beneficiary Charges to Total Charges Applied to Allowable Cost (RCCAC)

- (1) Beginning February 3, 2004, an alternative payment method (APM) is adopted and available for election. Under RCCAC, allowable costs are determined using applicable Medicare cost principles, as addressed in 42 CFR and CMS Publication 15-1, and allowable costs are allocated to Medicaid using the percentage of Medicaid billed charges to total charges for all patients. Total allowable costs are multiplied by the Medicaid charge percentage to determine the amount of allowable cost to be paid by Medicaid. Interim payments will be made on the basis of billed charges and valid claims processed and paid by Medicaid will reduce the final settlements. Third party liability (TPL) collections for Medicaid patients will also be considered as claim reimbursements in completing cost settlements.
- (2) FQHCs participating in the alternative payment method will provide DHCF with annual cost reports and other information required by DHCF within ninety (90) days from the close of their fiscal year-end to include the provider calculations of their anticipated settlement. DHCF will review submitted cost reports and provide a preliminary payment, if applicable, to FQHCs on the basis of a desk settlement. About 6 months after the FQHC's fiscal year-end, DHCF will conduct a desk review or audit of submitted cost reports and perform final settlements. This will allow for inclusion of late filed claims and adjustments processed after the submitted cost report was prepared. Claims data changes from the final settlement through one year will be added to the following year's settlement. If Medicaid over-payments to a provider occur, pay-back to the State is required. If underpayment occurs, a payment adjustment will be made to the FQHC.
- (3) The alternative payment method described herein will be compared with the reimbursements calculated using the PPS methodology described in A.9.a. The greater amount will be paid to the FQHCs.

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Approval Date 1-18-06

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Effective Date 1-1-05

A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) (Continued)

c. Scope of Service Changes

Scope of service changes must be substantiated by adequate documentation. FQHCs electing the PPS method must submit documentation with an estimate of the cost of the change in scope of service to receive an adjustment in their encounter rate. Scope changes need to be accounted for by all FQHCs because annual comparisons to APM need to be made. Actual detail cost elements need to be tracked in the general ledger accounts or otherwise to allow for verification and testing. Overstated estimated costs require pay-back. Underestimated costs will be reimbursed.

d. Managed Care Organization and Mental Health Settlements

For FQHCs servicing Medicaid clients of Managed Care Organizations (MCOs) and capitated MH organizations, the difference between FQHC costs minus MCO, MH and TPL reimbursement will be determined annually and settled. The determination of cost will be on the basis of the RCCAC as noted in Section A.9.b. Quarterly estimated payments will be made to FQHCs on the basis of the most recent prior year annual reconciliation.

10. RURAL HEALTH CLINICS (RHCs)

a. Prospective Payment System (PPS)

- (1) Payment for Rural Health Clinic services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. All Rural Health Clinics are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding year.
- (2) Payment rates will be set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that fiscal year. The clinic must supply documentation to justify scope of service adjustments.

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Effective Date 1-1-05

A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

10. RURAL HEALTH CLINICS (RHCs) (Continued)

a. Prospective Payment System (PPS) (Continued)

- (3) For newly qualified RHCs after State fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar case load, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics, and adjustments for increases or decreases in the scope of service furnished by the clinic during that fiscal year.
- (4) Until a prospective payment methodology is established, the state will reimburse RHCs based on the State Plan in effect on December 31, 2000. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

b. Managed Care Organization Settlements

In the case of any RHC which contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

c. Out-of-State Providers

RHCs located out-of-state that serve Utah Medicaid clients will be paid the reimbursement rate applicable to the state in which services are provided.

T.N. # 05-005 Approval Date 1-18-06

Supersedes T.N. # 04-003 Effective Date 1-1-05

C. LABORATORY AND RADIOLOGY SERVICES

Payment will be based on the established fee schedule unless a lesser amount is billed.
The amount billed cannot exceed the usual and customary charge to private pay patients.
Payment will not exceed the Medicare fee schedule as required by Section 2303 of P. L. 98-369.

T.N. # 87-37

Approval Date 11-9-87

Supersedes T.N. # 82-19

Effective Date 7-1-87

D. PHYSICIANS (Except Anesthesiologists)

1. INTRODUCTION

Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. In establishing the fee schedule, a single fee is established for each procedure code regardless of provider specialty.

2. FEE SCHEDULE BASED ON RELATIVE VALUES

The physician fee schedule is based on relative value units unless otherwise specified in the "Alternative Fees Section." Weight for the CPT Codes are based on the 1994 Resource Based Relative Value Scale (RBRVS) published by HCFA. Special payment considerations are given for EPSDT services. When compared to billed charges, the annual payment for EPSDT services are approximately 25% higher than payments for other physician services. Similarly, maternity codes covering the deliveries are prices higher in response to OBRA requirements.

Physicians practicing in rural areas of the State are paid an additional 12%. Rural areas are defined as those areas in Utah outside of the Wasatch Front -- Davis, Weber, Utah and Salt Lake counties.

3. ALTERNATIVE FEES

When an RVS value is either not available or not appropriate, an alternative method will be used to establish the fee. In establishing alternative fees, reference will be made to the methodology included in the Medicare regulations covering "gap filling" for physician fees. In addition to professional judgments, consideration will be given to one or more of the following:

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Approval Date 7-3-96

Supersedes T.N. # 95-11

Effective Date 4-1-96

D. PHYSICIANS (Except Anesthesiologists)(Continued)

3. ALTERNATIVE FEES (Continued)

- a. Utah Medical payment history,
- b. Medicare fees,
- c. Practitioner fee schedules,
- d. Fee schedules from other states,
- e. Similar procedures with established fees,
- f. Medical determinations by physician consultants, and
- g. Private insurance payments.

There are some fees that are seldom billed and services that do not fit into the routine HCPCS coding structure. When it is not practical to establish a specific fee, payments may be determined by either calculating a percent of billed charges or by using the professional judgment of a physician consultant. The percent of billed charges is determined by projecting the average percent of billed charges paid for surgery codes at the end of the fiscal year.

4. ECONOMIC INDEX

An economic index may be used to adjust the fee schedule. Each year the Department of Health will specify the economic indices. Input from the providers and the Medical Care Advisory Committee will be considered in determining the increase.

5. MULTIPLE AND BILATERAL PROCEDURES

The primary surgical procedure with the highest payment rate is paid based on 100% of the established Medicaid fee. The second highest payment rate is paid based on 50% of the established fee schedule. Payment for the other lower payment rates is made at 25% of the established fee schedule for multiple and bilateral procedures. When CPT modifiers are used, the rate is adjusted for CPT modifiers before the percentages are applied for multiple and bilateral procedures. Provision is made for multiple units billed for designated procedure codes to pay at 100% of the established Medicaid fee schedule. For example, code 15101 provides a fee to be paid for each 100 square centimeters of skin transplant. Such designated procedures are paid at 100% of the established fee regardless of the number of times that the code is billed.

T.N. # 96-02Approval Date 7-3-96Supersedes T.N. # 95-11Effective Date 4-1-96

D. PHYSICIANS (Except Anesthesiologists)(Continued)

6. SPECIAL MODIFIERS

Modifiers are described in the CPT-4 manual and incorporated in HCPCS. Physicians should bill usual and customary charges for their services. Usual and customary charges should reflect normal reductions for "reduced services" in accordance with normal billing practices. Payment for modifiers will be limited as follows:

- a. Modifier "22" is suspended for manual pricing when there is an accompanying post-operative report.
- b. Modifier "25" is covered when review indicates significant separately identifiable evaluation and management services.
- c. Modifier "26" has a separate fee in the payment schedule and pays according to the established fee schedule.
- d. Modifier "50" for bilateral procedures is paid as discussed in Section D-5 of this ATTACHMENT - Multiple and Bilateral Procedures.
- e. Modifier "51" for multiple procedures is paid as discussed in Section D-5 of this ATTACHMENT - Multiple and Bilateral Procedures.
- f. Modifier "52" for reduced service is paid at 50 percent of the established fee schedule.
- g. Modifier "53" for a discontinued procedure is paid at 50 percent of the established fee schedule.
- h. Modifier "54" is paid at 80 percent of the established fee schedule.
- i. Modifier "55" is paid at 20 percent of the established fee schedule.
- j. Modifier "56" is paid at 20 percent of the established fee schedule.
- k. Modifier "59" is covered when review indicates a distinct procedure from the primary procedure or the procedure was performed at a separate site.
- l. Modifier "62" is paid at 62.5 percent of the established fee schedule.
- m. Modifier "66" is suspended for manual review and is priced by Medicaid physician consultants.
- n. Modifier "73" (a facility bill modifier) is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the service. This modifier is to be paid at 50% of normal fee schedule payment.
- o. Modifier "76" is paid at 100 percent of the established fee schedule.
- p. Modifier "77" is paid at 100 percent of the established fee schedule.
- q. Modifier "80" for assistant surgeon is limited to 20 percent of the established Medicaid fee schedule.
- r. Modifier "81" for minimum assistant surgeon is limited to 15 percent of the established Medicaid fee schedule.

T.N. # 05-005 Approval Date 1-18-06

Supersedes T.N. # 00-010 Effective Date 1-1-05

D. PHYSICIANS (Except Anesthesiologists)(Continued)

7. ENHANCED PAYMENT RATES

Physicians providing services in rural areas of the state are paid a rate differential equal to 112 percent of the physician fee schedule. Rural areas are defined as areas of the State of Utah outside of Weber, Davis, Salt Lake and Utah counties.

Physicians and practitioners employed by University of Utah Medical Group in urban areas will be paid at a rate commensurate with commercial insurance professional rate. Commercial insurance professional rate shall be calculated annually by comparing commercial insurance professional rate with Medicaid professional rate on a Net Charges basis ("Net Charges" means gross charges less contractual adjustments). This calculation will be completed in the quarter prior to any rate changes that may be necessary to maintain the commensurate rate principal discussed above. The yearly calculation mentioned above is predicated on the fact that one charge schedule is applied to all payers; i.e., that the "gross charge" is the same for all payer classes, other than "waiver" status payments which are excluded from the calculation for the same service. Anesthesiologists employed by the University of Utah Medical Group will be considered part of this enhanced payment methodology program, regardless of the anesthesiologist exception noted in this section [Section D, Physicians (Except Anesthesiologists)].

The rate differential payment made to the University of Utah Medical Group will be made as a separate quarterly payment to the teaching institution on behalf of the physicians and practitioners employed.

This will be effective for all services delivered on or after October 1, 2004.

8. RATE ADJUSTMENT -- ACCESS

To improve client access to physicians, payments are increased to providers who render significant services to Medicaid clients. Significant services are defined as total annual relative value units (RVUs) times .2698 and the resulting product being greater than \$100. The payment to each qualifying provider is the annual RVUs times .2698. For example, if the annual RVUs for Dr. Jones are 1,500 units, the payment would be \$404.70.

T.N. # 05-017 Approval Date 5-25-06

Supersedes T.N. # 04-013 Effective Date 7-1-05

D. PHYSICIANS (Except Anesthesiologists)(Continued)

9. PAIN MANAGEMENT

The pain management program uses two codes for billing. (a) CPT code 99245 is used to bill for an all-inclusive package of three services (comprehensive history, comprehensive physical examination and high complexity of decision making) regarding a plan to treat and manage the person's pain. These services must be performed by an MD and billed after the second patient visit. (b) HCPCS Code S5190 is used to bill if services are provided by a psychologist. Fees are paid according to the Medicaid fee schedule. Payment for services is only for physician services (no facility fee).

T.N. # 07-009

Approval Date 9-25-07

Supersedes T.N. # New

Effective Date 8-1-07

E. ANESTHESIOLOGIST/ANESTHETIST

1. INTRODUCTION

Payment is based on the lower of billed usual and customary charges or a calculated fee. Beginning with dates of service on or after February 1, 1995, anesthesiology service is billed and paid under a new system. This new system is based on the 1994 Relative Value Guide published by the American Society of Anesthesiologists (ASA). The initial Medicaid rate is \$14.10. During the first three months of operations, paid claims history will be compiled and evaluated. Since the \$14.10 is an estimated rate, it will be adjusted on May 1, 1995, for future periods so that payments will be budget neutral when compared to the old pricing system. In future years, the Medicaid rate will be increased based on economic trends and conditions. This section does not apply to anesthesiologists paid by or through the University of Utah Medical Group.

2. CALCULATED FEE

Payment is Basic Value plus Time Values plus Modifying Factors times Medicaid rate.

Basic value, time values, and modifying factors are defined in the Relative Value Guide published by the American Society of Anesthesiologists. Time Values are added to the basic value at the rate of one unit for each twelve minutes or fraction thereof.

T.N. # 05-017

Approval Date 5-25-06

Supersedes T.N. # 95-002

Effective Date 7-1-05

E. ANESTHESIOLOGIST/ANESTHETIST (Continued)

2. CALCULATED FEE (Continued)

a. Obstetrical Anesthesia

Because obstetrical anesthesia is unique and an anesthesiologist may attend more than one patient concurrently under continuous regional anesthesia, there will be a reduction in the unit value after the first hour of anesthesia time. During the second hour of anesthesia, the unit value will be reduced by 50%. During the third and each succeeding hour of anesthesia, the unit value will be reduced by 75%.

b. Modifying Units

- i. Modifying units may be added to the basic value where increased risk and special technical skills are involved or necessary for extremes of age (under one year or over 70 years), two modifying units may be added.
- ii. When anesthesia is administered under extenuating circumstances away from the operating room suite, two modifying units may be added.
- iii. Utilization of total body hypothermia, five units may be added.
- iv. Utilization of controlled hypotension, five units may be added.

T.N. # 93-02

Approval Date 5-21-96

Supersedes T.N. # 87-37

Effective Date 1-1-93

F. PODIATRISTS

Payments are based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The fee schedule is described in section D "Physicians".

T.N. # 87-37

Approval Date 11-9-87

Supersedes T.N. # 82-19

Effective Date 7-1-87

G. OPTOMETRISTS

The State developed fee schedule rates are the same for both public and private providers of optometric services and the fee schedule and any annual/periodic adjustments to the fee schedule are published. Payments are based on the established fee schedule unless a lower amount is billed. The fee schedule is described in section D "Physicians".

T.N. # 05-008

Approval Date 9-8-05

Supersedes T.N. # 87-37

Effective Date 7-1-05

H. EYEGASSES

The State developed fee schedule rates are the same for both public and private providers of eyeglass services and the fee schedule and any annual/periodic adjustments to the fee schedule are published. Payments are based on the established fee schedule unless a lower amount is billed.

T.N. # 05-008

Approval Date 9-8-05

Supersedes T.N. # 93-021

Effective Date 7-1-05

I. DIAGNOSTIC, PREVENTIVE, SCREENING AND REHABILITATIVE SERVICES

This payment plan covers diagnostic and rehabilitative substance abuse treatment services when provided by or through a substance abuse treatment program under contract with a Local County Substance Abuse Authority and licensed in accordance with Section 62A-15-102, Utah Code Annotated, 2003, or as amended.

Diagnostic and rehabilitative substance abuse services are reimbursed by Medicaid on a fee-for-service basis. Medicaid payments will be the lesser of (1) the billed usual and customary charges to the general public; or (2) the established fee schedule. The usual and customary charge is the most frequently billed charge prior to discounts.

Special Modifiers

- a. Modifier "HQ" (group setting) is paid at 34.02 percent of the established fee schedule for individual Therapeutic Behavioral Services.
- b. Modifier "TD" (RN) is paid at 43.72 percent of the established fee schedule for Pharmacologic Management.

T.N. # 03-021

Approval Date 3-25-04

Supersedes T.N. # 98-07

Effective Date 10-1-03

J. HOME HEALTH SERVICES

Home Health services are paid a uniform fee per visit unless either a lower amount is billed. The fee schedule is developed with consideration given to the following factors: Professional input from Medicaid staff, prevailing usual and customary charges, Medicare reimbursement for services, reimbursement rates required to obtain provider participation. The uniform fee is established statewide and will be the same for all governmental and private providers. The agency's rates were set as of July 1, 2007, and are effective for services delivered on or after that date. The uniform fee schedule is available on the State Medicaid Website.

RURAL AREA EXCEPTIONS

Where travel distances to provide service are extensive, enhancements in the home health reimbursement rates are provided. These enhancements are available only in rural counties where one way travel distances from the provider's base of operations are in excess of 25 miles. Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah counties. In instances of travel of 50 miles or more, the Home Health fee schedule is multiplied by 1.75 to calculate the payment rate for applicable service codes.

SAN JUAN and GRAND COUNTIES EXCEPTION

To assure continued access to home health services for residents of San Juan County and Grand County, enhancements in home health reimbursement rates are provided. Effective July 1, 2007, for services provided in San Juan County and Grand County, the home health fee schedule is multiplied by 4.08 and 2.95, respectively, to calculate the payment rate for applicable service codes. These enhancement factors are applied irrespective of the distances traveled to provide these services and are in lieu of the rural area exceptions provided for other rural counties. Additionally, to compensate providers for delivering home health services in more remote areas, Medicaid payment is based upon a modifier for the two following zones:

Zone 1: For Aneth and Hatch Trading Posts, and Mexican Hat and Montezuma Creek residents or eligibles, Home Health Agency (HHA) services are billed under Modifier "UA" and mean that a factor or multiplier of 7.12 is applied (multiplied) by the existing HHA fee schedule.

Zone 2: For Monument Valley residents or eligibles, HHA services are billed under Modifier "UB" and mean that a factor or multiplier of 15.02 is applied (multiplied) by the existing HHA fee schedule.

T.N. # 07-003 Approval Date 4-4-08

Supersedes T.N. # 06-009 Effective Date 7-1-07

K. MEDICAL SUPPLIES AND EQUIPMENT

1. GENERAL

For items of DME that have a HCPC code (including power wheelchairs), payment will be made to the supplier based on the lowest of:

- a. Billed usual and customary charges to the general public, or
- b. The established Medicaid fee schedule, a price discounted from the Medicare allowable for the region, or the negotiated price, or
- c. The lowest qualified bidder who meets all quality of care and service delivery requirements.

2. SPECIALIZED WHEELCHAIRS

Manual wheelchairs with special configurations, which do not fit into HCPC definitions, will be priced using the following criterion:

- a. Prior Approval of all Pricing -- "Specialized manual wheelchairs" require prior approval by the Medicaid agency. Approval is required for all components used to customize the wheelchair. Components must be:
 - i. Described in writing,
 - ii. Priced using manufacturers' list, and
 - iii. Approved by the Medicaid agency.
- b. Manufacturers Published Catalog Price Less Discount -- "Specialized manual wheelchairs," not described by HCPC coding, are manually priced and are priced at the manufacturer's published catalog price less 25%.

Wheelchair components without a specific HCPC code are priced at Manufacturers' list price less 40%.

T.N. # 07-011

Approval Date 9-11-07

Supersedes T.N. # 95-18

Effective Date 8-1-07

K. MEDICAL SUPPLIES AND EQUIPMENT (Continued)

3. DURABLE MEDICAL EQUIPMENT NOT COVERED BY HCPC DEFINITIONS

This policy is intended to address isolated problems where HCPC definitions and related fees do not correlate with equipment approved by the Medicaid Agency. Providers should not look to this policy for routine pricing. The policy assures that suppliers are not paid less than the acquisition cost paid to the equipment manufacturer.

4. PRICING POLICY

This policy is limited to durable medical equipment that is not covered by specific HCPC codes, but is approved as medically necessary by the Medicaid Agency. The DME must be approved and payment will be the greater of:

- a. Manufacturers' list price less 40%.
- b. Manufacturers' invoice, including shipping, but net of all discounts, plus an add-on of 10% with a ceiling of \$100.

T.N. # 07-011

Approval Date 9-11-07

Supersedes T.N. # 95-15

Effective Date 8-1-07

L. CLINIC SERVICES

Clinic services are paid differently depending on the type of services rendered. Such payments are limited to the amount paid by Medicare as specified in 42 CFR 447.321. Subject to these limitations, payments are determined as follows:

1. Dialysis Clinics -- Payment for renal dialysis is based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges. Fees are based on the Medicare payment in Salt Lake County for dialysis.
2. Surgical Centers -- Payment is based on a percentage of usual and customary billed charges. The percentage is established by the Pricing Unit in the Bureau of Policy and Planning and sent to the Bureau of Medicaid Management Information Systems for claims payment.
3. Alcohol and Drug Clinics -- Payment is based on the established fee schedule unless a lower amount is billed. Fees will be set based on historical payments for specific HCPC codes.
4. Licensed Birthing Centers -- Payment is based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges. Fees are based on discounted rates established for physicians.
5. Clinic Services for Physical Therapy and Occupational Therapy - Payments for physical/occupational therapy are based on the established fee schedule unless a lower amount is billed. Fees are established by discounting historical charge, by professional judgement, and by the physical therapy and occupational therapy fee schedule. Since the amount of physical therapy and occupational therapy is limited, the select case management committee of the facility will determine which type (physical therapy or occupational therapy) will be provided for the patient by the clinic facility. The amount of physical therapy provided will affect the amount of occupational therapy available, and vice versa.

T.N. # 99-14

Approval Date 2-8-00

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Effective Date 10-1-99

M. DENTAL SERVICES AND DENTURES

The State developed fee schedule rates are the same for both public and private providers of dental services and the fee schedule and any annual/periodic adjustments to the fee schedule are published. Payments are based on the established fee schedule unless a lower amount is billed.

Urban Counties

As an incentive to improve client access to dental services in urban counties (Weber, Davis, Salt Lake, and Utah counties), dental providers (excluding UMAP/state-funded clinics) treating 100 or more clients per year will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less. Also, dentists willing to sign an agreement to see 100 or more clients during the next year will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less.

Rural Counties

As an incentive to improve client access to dental services in rural counties (all counties except Weber, Davis, Salt Lake, and Utah), dental providers in these counties (including UMAP/state-funded clinics) will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less.

T.N. # 05-007

Approval Date 8-2-05

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Effective Date 7-1-05

N. PHYSICAL THERAPY

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. Fees are established by discounting historical charges, and by professional judgment.

OCCUPATIONAL THERAPY

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. Fees are established by discounting historical charges, and by professional judgment.

T.N. # 99-03

Approval Date 8-10-99

Supersedes T.N. # 87-37

Effective Date 1-1-99

O. PROSTHETIC DEVICES AND BRACES

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. Fees are established by discounting historical charges, by professional judgment and by discounting published price lists.

T.N. # 87-37

Approval Date 11-9-87

Supersedes T.N. # 82-25

Effective Date 7-1-87

P. SPEECH PATHOLOGY

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The fees are established by discounting historical billed charges, and by professional judgment to encourage efficient, effective and economical services.

T.N. # 87-37

Approval Date 11-9-87

Supersedes T.N. # 82-25

Effective Date 7-1-87

Q. AUDIOLOGY

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The fees are established by discounting historical billed charges, and by professional judgment to encourage efficient, effective and economical services.

T.N. # 87-37

Approval Date 11-9-87

Supersedes T.N. # 82-25

Effective Date 7-1-87

R. TRANSPORTATION

1. Ambulance -- Payment will be made on an established Medicaid fee schedule. The fee schedule will include base rate, mileage rate, oxygen fee and waiting time. The fee schedule will include both ground, air and water transportation.
2. Taxi -- Payment will be based on a percentage of usual and customary billed charges.
3. Special Services -- These services include Ambucar and Servicar. Payment will be the lower of the usual and customary charge or the established fee schedule for Medicaid.
4. Bus Service -- Payment will be the rates established by contract between the Utah Transit Authority and Medicaid. If there is no contract, payment will be the same as the fares paid by the general public.

T.N. # 87-37

Approval Date 11-9-87

Supersedes T.N. # 86-33

Effective Date 7-1-87

S. PRESCRIBED DRUGS

Prescribed drugs will be reimbursed based on an established product cost plus a dispensing fee. The payment for individual prescriptions cannot exceed the amount billed. The amount billed must be the usual and customary charge to the private pay patient. The following methodology is used to establish Medicaid payments:

Except for special category fees, reimbursement will be the lower of:

1. The Utah maximum allowable cost (MAC) plus a reasonable dispensing fee or the provider's usual and customary charge (billed charge) to the general public;
2. The Utah estimated acquisition cost (EAC) plus a reasonable dispensing fee or the provider's usual and customary charge (billed charge) to the general public.

Federal "Upper Limit"

The federal upper limit is the maximum allowable ingredient cost reimbursement established by the Department of Health and Human Services, Health Care Financing Administration, for selected multiple-source drugs. The aggregate cost of product payment for the drugs on the federal upper limit list will not exceed the aggregate established by Health Care Financing Administration.

Average Wholesale Price

The Average Wholesale Price (AWP) is determined for each drug by the Utah contract with American Druggist, Blue Book First Data Bank. They provide a monthly update of drug prices for the Reference File. First Data Bank used AWP from Wholesalers in many states for determining AWP in specific regions.

Utah MAC

Utah MAC is the Maximum Allowable Cost reimbursement established by the Utah Department of Health, Division of Health Care Financing, for selected multiple-source (generic) drugs not appearing on the federal upper limit list. These drugs are listed in the Pharmacy Provider Manual.

T.N. # 89-02

Approval Date 3-14-89

Supersedes T.N. # 87-37

Effective Date 1-1-89

S. PRESCRIBED DRUGS (Continued)

Utah EAC

The Utah Estimated Acquisition Cost (EAC) is currently AWAP -15%. This estimate has been established using information provided by a survey conducted by the Utah Department of Health.

Dispensing Fee

In setting the basic dispensing fee, the state will give consideration to costs shown on periodic operation surveys, in-house studies of dispensing costs, national and regional data, and economic trends and conditions.

Special Category Fee

6. Payment for insulin, birth control pills, and non-legend (OTC) drugs will be the lowest of:
 - a. Billed charge;
 - b. EAC + special category fee C;
 - c. Utah MAC + special category fee C; or
 - d. AWP + special category fee not to exceed the maximum on the Federal upper limits list.

2. Payment for non-legend OTC antacid liquids will be the lowest of:
 - a. Billed charge;
 - b. EAC + special category fee F;
 - c. Utah MAC + special category fee F; or
 - d. AWP + special category fee not to exceed the maximum on the Federal upper limit list.

3. Differential fee payment for select drugs reconstituted for Home I.V. infusion as typically prepared by a specialty pharmacy. Specialty pharmacies have low volume but high overhead expenses. The Department of Justice (DOJ) in year 2000 repriced the AWP for 437 NDC specific products. The repriced products necessitated four new dispensing fees. The four fees are defined as category J, category K, category L, and category M.

T.N. # 03-005

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Supersedes T.N. # 01-004

Effective Date 1-1-03

S. PRESCRIBED DRUGS (Continued)

Special Category Fee (Continued)

Table 1 shows unit values assigned for each category to establish the fee. An asterisk (*) equals one unit value. Items with two or more asterisks have a higher value.

Table 1
Home Infusion Drug Categories

Category 'B' or 'C'	Category 'J'	Category 'K'	Category 'L'	Category 'M'
Traditional: technician input Point-of-Sale Pharmacist input Fixed overhead costs	dispensing fee B or C plus: *Labor II factor *clinical monitoring *prefilled syringes/PB *horizontal hood *technical input	dispensing fee J plus: ****clinical monitoring *** quality assurance *** labor factor	dispensing fee K plus: *Replacement into individual doses such as a syringe *recalculations from vial to syringe to bag *large bulk inventory costs *peer review	dispensing fee L plus: *Double gloves **Gown **Vertical Hood *labor factor V *OSHA documentation *Special handling *special storage *clean room *hazardous waste
dispensing fee B or C	dispensing fee J	dispensing fee K	dispensing fee L	dispensing fee M

Special Category Fee

The special category fee is a negotiated fee initially developed in cooperation with the Utah pharmaceutical Association and other key pharmacists to apply to specific drugs historically advertised and dispensed to the general public at minimal prices. This fee may be periodically changed to reflect changing market forces.

T.N. # 01-04

Approval Date 6-22-01

Supersedes T.N. # 00-12

Effective Date 4-1-01

S. PRESCRIBED DRUGS (Continued)

Rural Pharmacies

In recognition of lower volume and higher acquisition costs, rural pharmacies are paid a \$.50 dispensing fee differential. The differential is paid in addition to the dispensing fee paid to urban pharmacies. Rural is defined as those pharmacies located outside of Weber, Davis, Utah and Salt Lake counties.

T.N. # 93-02

Approval Date 5-21-93

Supersedes T.N. # 90-28

Effective Date 1-1-93

T. MEDICARE/MEDICAID CROSSOVER SERVICES

Medicaid payment for specified Medicare crossover claims will be the lower of the allowed Medicaid payment rate less the amounts paid by Medicare and other payors, or the Medicare coinsurance and deductibles. The specified cross-over claims are defined as: inpatient hospitals, outpatient hospitals, medical supplies and physicians. Medical supplies are further defined as billings from medical suppliers and pharmacies who bill medical supplies. Physicians are further defined to include osteopaths, podiatrists, independent laboratories and independent radiology providers. Anesthesiologists are excluded, however. In the event Medicaid does not have a price for codes included on a cross-over claim, the Medicare coinsurance and deductible will be paid.

Medicaid payment for all other allowed Medicare cross-over claims, will be the amount of coinsurance and deductible billed by Medicare.

T.N. # 89-07

Approval Date 3-9-89

Supersedes T.N. # 88-06

Effective Date 1-1-89

LICENSED CERTIFIED REGISTERED NURSE-MIDWIFE SERVICES

Payments are based on the established fee schedule for selected HCPCS codes unless a lower amount is billed. Selected HCPCS codes are established in compliance with HIPAA requirements. The amount billed cannot exceed usual and customary charges to private-pay patients. Payment for registered nurse-midwife services includes the physician's collaboration fee for the co-management of the case.

Rate Adjustment for Rural Areas

Effective October 1, 1991, licensed certified registered nurse-midwives who provide services in rural areas of the State will be paid the lower of usual and customary charges or rate equal to 112% of the established Medicaid fee schedule. Rural areas are defined as areas of the State outside of Weber, Davis, Salt Lake and Utah counties.

T.N. # 03-013

Approval Date 2-4-04

Supersedes T.N. # 91-18

Effective Date 10-1-03

PEDIATRIC AND FAMILY NURSE PRACTITIONERS

Approved codes listed in the physicians' Current Procedural Terminology (CPT) manual may be billed by licensed pediatric and family nurse practitioners. The approved codes will be designated by the Division of Health Care Financing. Payment for approved services will be made at the lower of the usual and customary charge or the established physician's fee schedule.

Rate Adjustment for Rural Areas

The 12% rate differential, not to exceed usual and customary charges, will be paid for services rendered in rural Utah. Rural Utah is defined as areas of the State outside of Weber, Davis, Salt Lake and Utah counties.

Billing Arrangements

When service is provided by a licensed nurse practitioner employed and working under supervision in a group practice, private office, community health center, or local health department, the supervising provider shall bill for the service according to their usual and customary fee schedule.

When service is provided by a licensed nurse practitioner working in a private independent practice, the licensed nurse practitioner shall bill according to their usual and customary fee schedule.

T.N. # 91-18

Approval Date 2-28-92

Supersedes T.N. # 90-31

Effective Date 10-1-91

TARGETED CASE MANAGEMENT SERVICES

Targeted Case Management services for pregnant women are paid based on the established fee schedule for one month of service. Payment is limited by the usual and customary charges of the providers.

T.N. # 93-02

Approval Date 5-21-93

Supersedes T.N. # 88-05

Effective Date 1-1-93

TARGETED CASE MANAGEMENT - CHRONICALLY MENTALLY ILL

This payment plan covers targeted case management services for the chronically mentally ill.

Fee-for-Service (FFS) Payments

Medicaid payments to fee-for-service mental health centers for targeted case management services for the chronically mentally ill are the lesser of: (1) the billed usual and customary charges to the general public, or (2) the established fee schedule. The usual and customary charge is the most frequently billed charge prior to discounts.

Retroactive Cost Settlement

San Juan and Wasatch counties are not capitated and are subject to annual cost settlements. Based on the cost settlements, final Medicaid payments to the community mental health centers in these counties will be the lesser of: (1) the billed usual and customary charges to the general public, (2) the reasonable cost of providing the service, or (3) the established fee schedule. Annual retroactive settlements are made using cost reports filed by the centers. Such reports are prepared using Medicare regulations to define allowable costs. In applying the cost reimbursement principles, a separate cost is calculated for each operating unit.

T.N. # 03-024

Approval Date 9-1-04

Supersedes T.N. # 93-002

Effective Date 10-1-03

TARGETED CASE MANAGEMENT - HOMELESS

Payments for targeted case management services to homeless Medicaid recipients are made on a fee-for-service basis. Rates are based on 15-minute units of service.

T.N. # 93-02

Approval Date 5-21-93

Supersedes T.N. # 90-22

Effective Date 1-1-93

TARGETED CASE MANAGEMENT - HIV/AIDS

Payment for targeted case management services to clients having a diagnosis of HIV/AIDS will be on a fee-for-service basis. Rates are based on 15-minute units.

T.N. # 93-02

Approval Date 5-21-93

Supersedes T.N. # 92-21

Effective Date 1-1-93

TUBERCULOSIS -- DIRECTLY OBSERVED THERAPY

The payment for directly observed therapy is based on a weekly fee. Such fees are established to take into account the cost of the service site, service complexity, service intensity, and existing relationship between the provider and the recipient, record of compliance and completion of therapy. Cost used to negotiate fees include the estimated number of hours incurred by staff times the hourly wage rate with fringe benefits. In addition, the projected cost for medical supplies, equipment and facilities with reasonable overhead are considered during negotiations. The projected "reasonable costs" will be the upper payment limit for negotiated rates. Access to these fees will be available only to those providers who sign Provider Agreements. Fees paid to the provider will be negotiated for each client.

T.N. #	<u>03-008</u>	Approval Date	<u>5-23-03</u>
Supersedes T.N. #	<u>94-003</u>	Effective Date	<u>1-15-03</u>

TARGETED CASE MANAGEMENT - SUBSTANCE ABUSE

Payment for targeted case management services to clients with a substance abuse disorder will be made on a fee-for-service basis to qualified providers. Medicaid payments will be the lesser of (1) the billed usual and customary charges to the general public; or (2) the established fee schedule.

T.N. # 95-14

Approval Date 12-6-95

Supersedes T.N. # New

Effective Date 10-1-95

TARGETED CASE MANAGEMENT SERVICES FOR MEDICAID HMO ENROLLEES AND
POTENTIAL ENROLLEES

Total reimbursement for targeted case management services for HMO enrollees is based on historical cost adjusted annually (effective July 1) based on Legislatively approved cost of living and merit increases.

T.N. # 01-22

Approval Date 12-6-01

Supersedes T.N. # New

Effective Date 7-1-01

PRESUMPTIVE ELIGIBILITY/EXPANDED PRENATAL SERVICES

Payments are based on the established fee schedule for the defined services unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients.

T.N. # 93-02

Approval Date 5-21-93

Supersedes T.N. # 88-05

Effective Date 1-1-93

PERSONAL CARE SERVICES

Medicaid payments for personal care services will be based on a fee schedule unless a lower amount is billed. Fees will be established based on the historical cost adjusted by economic trends and conditions. Providers must bill their usual and customary fees.

T.N. # 93-02

Approval Date 5-21-93

Supersedes T.N. # 87-38

Effective Date 1-1-93

MENTAL HEALTH DIAGNOSTIC AND REHABILITATIVE SERVICES

This payment plan covers diagnostic and rehabilitative mental health services provided by comprehensive community mental health centers licensed by the Department of Human Services.

Fee-for-Service (FFS) Payments

Medicaid FFS payments are the lesser of (1) the billed usual and customary charges to the general public, or (2) the established fee schedule. The usual and customary charge is the most frequently billed charge prior to discounts.

FFS payments are paid to capitated mental health centers for services provided to foster care children (children in state custody). Foster care children are excluded from the capitation program for outpatient care services.

The FFS payments are the same regardless of whether the services are provided face-to-face, or through the telehealth mode of delivery. For telehealth services, the comprehensive mental health center may not be reimbursed for the services of the presenting provider. The center may only be reimbursed for the service of the consultant. The services of a consultant will be billed by the center, using the established HCPC codes, and the "GT" modifier.

Special Modifiers

- a. Modifier "HQ" (group setting) is paid at 34.02 percent of the established fee schedule for individual Therapeutic Behavioral Services.
- b. Modifier "TD" (RN) is paid at 43.72 percent of the established fee schedule for Pharmacologic Management.

Monthly Capitation Payments

Medicaid clients enrolled in capitation program, the Prepaid Mental Health Plan, receive diagnostic and rehabilitative mental health services from the designated community mental health center contractors. The State Medicaid program pays contractors monthly premiums similar to private insurance premiums. Payments are consistent with the 1915(b) waiver which authorizes the Prepaid Mental Health Plan. Premium payments are prospective based on the terms of the contract. Capitated community mental health centers cover all counties except San Juan County and Wasatch County. Community mental health centers serving these counties are paid on the FFS basis outlined above.

T.N. # 03-019

Approval Date 3-25-04

Supersedes T.N. # 02-16

Effective Date 10-1-03

MENTAL HEALTH DIAGNOSTIC AND REHABILITATIVE SERVICES (Continued)

Retroactive Cost Settlement

San Juan and Wasatch counties are not capitated and are subject to annual cost settlements. Based on the cost settlements, final Medicaid payments to the community mental health centers in these counties will be the lesser of, (1) interim fee-for-service payments or, (2) the reasonable cost of providing the service. Interim fee-for-service payments were based on the lesser of the billed usual and customary charges to the general public and/or the established fee schedule. Annual retroactive cost settlements are made using cost reports filed by the centers. Such reports are prepared using Medicare regulations to define allowable costs. In applying the cost reimbursement principles, Medicaid costs are identified separately for each mental health service.

T.N. # 03-019

Approval Date 3-25-04

Supersedes T.N. # 02-16

Effective Date 10-1-03

OTHER DIAGNOSTIC, PREVENTIVE, SCREENING, AND REHABILITATIVE SERVICES

Poison Control Center

Payment for the State Poison Control Center will be in the amount established by contract between the Division of Family Health Services and the Division of Health Care Financing. This contract will be renegotiated annually based on the estimated percentage of Medicaid eligibles in the population served by the Center.

Telehealth

Payment for approved Telehealth services for Special Health Care Needs Children are based on the established fee schedule, unless a lower amount is billed.

Diabetes Self-Management Training

Payments for approved Diabetes Self-Management Training are based on the established fee schedule, unless a lower amount is billed.

T.N. # 99-13

Approval Date 2-1-00

Supersedes T.N. # 99-08

Effective Date 10-1-99

PAYMENT FOR PRIVATE DUTY NURSING

Payment for private duty nursing provided to ventilator-dependent individuals will be calculated by multiplying the fixed hourly rate for each level of nursing (RN or LPN) by the number of hours authorized by the Medicaid agency. Payments will not exceed the usual and customary charges to private-pay patients.

T.N. # 93-02

Approval Date 5-21-93

Supersedes T.N. # 91-14

Effective Date 1-1-93

PAYMENT FOR HOSPICE SERVICES

Agency Only Services

For recipients who are not in a nursing home, Medicaid payments for hospice services will be made at one of the four predetermined rate categories that coincides with the categories established under Medicare. The rates will be based on the Medicare rates for Utah. For each day that an individual is under the care of a Medicare-certified hospice agency, the hospice agency will be paid in accordance with the established Medicare fee schedule. Payment rates are based on the type and intensity of the services furnished to the individual for a given day according to one of the following levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care. All of these levels of care are paid on a per diem basis other than continuous home care that is paid on an hourly basis. Additionally, the hospice payments will be adjusted according to recognized geographic areas to reflect differences in the wage index as published by the Centers for Medicare and Medicaid Services (CMS). Payments are made according to the area in which the service was provided, not according to the billing office location. Payment to the hospice agency maybe considered as retroactive for up to three months prior to the individual becoming Medicaid eligible for the service provided, if the hospice service met the prior authorization criteria at the time service was delivered and if no other provider was reimbursed by Medicaid or any other payer for care related to the individual's terminal illness. The hospice agency must provide documentation to the Medicaid agency that demonstrates its service met all prior authorization criteria at the time of delivery.

Agency Services Delivered in Conjunction with Nursing Home Services

For recipients in a nursing facility who elect to receive hospice service from a Medicare-certified hospice agency, Medicaid will pay the hospice agency an additional per diem (for routine home care and continuous home care days only) to cover the cost of room and board in the nursing facility. The room and board rate will be 95 percent of the amount that Medicaid would have paid to the nursing facility or ICF/MR provider (facility/provider "specific rate") if the recipient had not elected to receive hospice care. In the event a Medicare certified facility provides hospice services and is not Medicaid certified, the room and board rate will be 95 percent of the statewide average Medicaid reimbursement rate for nursing facilities. With the election to receive hospice services, Medicaid payment to the nursing facility discontinues and the hospice agency pays the nursing facility the cost of room and board. In this context, room and board costs are for the performance of personal case services that include daily living assistance, social activities, administration of medication, room maintenance, supervising and assisting in the use of durable medical equipment and prescribed therapies, and other services associated with a nursing home inpatient stay.

T.N. # 06-008 Approval Date _____

Supersedes T.N. # 05-001 Effective Date 4-1-06

PAYMENT FOR HOSPICE SERVICES (continued)

Limitation for Inpatient Care

The total payment to the hospice agency for inpatient care (general or LTC room and board) is subject to a limitation that total inpatient care days for Medicaid recipients not to exceed 20 percent of the total days for which these individuals had elected hospice care. Individuals with AIDS are excluded from this limit and therefore the "excess" days are not counted against the provider. This limitation is applied on an agency wide basis and is not applied to individual patient stay services. At the end of each cap period, the Department calculates a limitation on payment of inpatient care for each hospice, to ensure that Medicaid payment is not made for days of inpatient care that are in excess of 20 percent of the total number of days of hospice care furnished to Medicaid recipients. The hospice agency then repays the Medicaid program a "prorated" share of total inpatient payment. This repayment will be computed as follows: [{"Excess" Medicaid inpatient days/total paid Medicaid inpatient days} X (payment rate per diem)].

T.N. # 05-001

Approval Date 10-6-05

Supersedes T.N. # New

Effective Date 7-1-05

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES

Unless otherwise indicated below, payment for EPSDT services is based on the established fee schedule unless a lower amount is billed.

Orthodontic Services

A fixed fee is paid for attaching the approved orthodontic appliance. In addition, a fixed fee is paid every three months for maintenance service. The maximum number of payments for maintenance is eight quarterly payments. Total payments for the appliance and for the maintenance service are limited to usual and customary charges.

Diagnostic, Preventive, Screening, and Rehabilitative Services

Early Intervention Services -- Providers of early intervention services will be paid on a fixed monthly rate. The rate is based on historical cost for FY 1996 inflated forward annually using the UCPI-U all services index published by the U.S. Department of Labor. Payment is intended to cover all early intervention services outlined in the child's Individual Family service Plan (IFSP). Providers may bill for the monthly rate when at least one face-to-face contact is made, but may only bill once in each month when services are given.

Skills Development Service -- Payment is based on the average cost per day for services received. Historical costs are used to establish interim payments. Actual costs are used to determine final payment. Except for the first period of covered services, the cost settlement will be for a twelve-month period. Allowable costs are defined by HCFA Pub. 15-1. Direct costs are defined as the total compensation, including benefits, of the staff who provide "hands-on" care. Total compensation for the direct staff at the school is divided between "academic educational" and "functional skills development and maintenance." Other costs are allocated using direct costs for "academic educational" and "functional skills." Total days are divided into the accumulated "functional skills" costs, including indirect cost allocations, to arrive at an average cost per day.

T.N. # 98-09

Approval Date 10-20-98

Supersedes T.N. # 93-17

Effective Date 7-01-98

PAYMENT FOR TARGETED CASE MANAGEMENT SERVICES FOR EPSDT ELIGIBLES

Payment for targeted case management services for EPSDT eligibles is made on a fee-for-service basis. A separate prospective rate is established for each type of targeted case management provider identified below. In accordance with Federal Office of Management and Budget Circular No. A-87 requirements, payments made to governmental service providers shall not exceed the costs of providing such services.

Independent Professional: Rates are established on the basis of the historical cost of the service. To establish an initial rate, the provider's historical costs are inflated by the Consumer Price Index, Urban-All Items, published by the U. S. Department of Labor. Rate adjustments are made on the basis of periodic cost studies. Rates are based on a 15-minute unit of service.

Agency Provider without RMS Capability: Rates are established on the basis of the historical cost for the service. To establish an initial rate, the provider's historical costs are inflated by the Consumer Price Index, Urban-All Items, published by the U. S. Department of Labor. Rate adjustments are made on the basis of periodic cost studies. Rates are based on a 15-minute unit of service.

Agency Provider with RMS Capability: Rates are based on an enrolled agency's average allowable cost to provide a monthly unit of targeted case management services to an eligible recipient. Rates will be authorized for a period of 12 months. Except for the initial period, an agency's rate will be calculated as follows:

T.N. # 00-05

Approval Date 6-28-00

Supersedes T.N. # 94-17

Effective Date 1-1-00

PAYMENT FOR TARGETED CASE MANAGEMENT SERVICES FOR EPSDT ELIGIBLES
(Cont.)

- Compute: the Agency's actual total cost for the most recently completed 12 month period for which actual cost data exist, including (1) the salaries and benefits of case managers, their direct supervisory and support staff, and their indirect administrative staff, and (2) other operating costs including travel, supplies, telephone, and occupancy cost, and indirect administrative costs in accordance with Circular A-87. To determine the agency's "allowable costs", subtract from its total costs all personnel, operating, occupancy, and indirect administrative costs that are both unrelated to the delivery of Medicaid's scope of targeted case management services and are not allocated by the RMS.
- Multiplied by: the percentage of time spent by agency personnel performing Medicaid allowable targeted case management services and related indirect activities on behalf of clients, ages birth through 20 years (regardless of the client's Medicaid eligibility) during the 12 month period. This percentage is derived from random moment time studies (RMS).
- Multiplied by: the percentage of the agency's clients (regardless of Medicaid eligibility) who received a Medicaid allowable targeted case management service during the period.
- Equals: total allowable costs incurred by the agency to provide and support Medicaid's scope of targeted case management services.
- Divided by: 12 months.
- Equals: the agency's average allowable monthly cost to provide and support Medicaid's scope of targeted case management services on behalf of individuals in the target group.
- Divided by: the average monthly number of agency's clients in the target group (ages birth through 20 years regardless of Medicaid eligibility) who received a covered case management service during the period.
- Equals: the agency's monthly allowable cost per targeted case management recipient in the target group. This cost equals the monthly fee for service amount that the agency will be authorized to claim for each EPSDT eligible recipient in the target group who received one or more covered targeted case management services that month. Documentation of case management services delivered will be retained in the service worker case files.

When determining an agency's initial rate, the Medicaid agency will apply the same calculations described above, but may use less than 12 months of data in calculating the rate. This initial rate may be in effect for less than a 12 month period.

T.N. # 00-05 Approval Date 6-28-00
Supersedes T.N. # New Effective Date 1-1-00

PSYCHOLOGISTS

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The fee schedule is developed from the paid claims history file.

T.N. # 94-27

Approval Date 3-3-95

Supersedes T.N. # New

Effective Date 1-1-95

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE
STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES

Diagnostic, Screening, Preventive, and Rehabilitative Services

MENTAL HEALTH SERVICES

1. Skills development programs are reimbursed a daily payment rate.
Comprehensive Residential programs - The daily payment rate for comprehensive residential programs is an all-inclusive rate that covers all diagnostic and rehabilitative services provided to Medicaid clients in the program.

Group Homes - The daily payment rate for group homes covers mental health evaluations, individual and group therapy, individual and group behavior management, and skills development services. Other needed diagnostic and rehabilitative mental health services, including psychiatric evaluations, psychological testing, and medication management, are paid on a fee-for-service basis according to #2 below.

Family-based foster care programs - The daily payment rate for family-based programs covers mental health evaluations and skills development services provided in the family-based health services, including psychiatric evaluations, psychological testing, individual and group therapy, individual and group behavior management, medication management, and skills development services provided in a treatment setting outside of the family-based program, are paid on a fee-for-service basis according to #2 below.

Each of the three skills development program types will have a daily rate. The daily payment rate for Medicaid-covered services is a fixed rate paid for all Medicaid clients in the specified program. The daily payment rate is set prospectively using historical costs. Each year the rate will be inflated by an amount not to exceed the medical component of the CPI-U. Payment for up to eight absent days per month is allowed for skills development programs. Days the client is in a hospital, nursing facility, or detention center are not covered and may not be billed to Medicaid by the skills development program. The daily payment rate is net of room and board. Room and board costs are defined using IV-E definitions for each facility.

2. All other diagnostic and rehabilitative mental health services not covered in the daily payment rate, or that are provided to clients who are not in a skills development program, are paid using a uniform fee schedule. Services are defined by HCPC codes and prices using a fixed fee schedule. Payments are made on a fee-for-service basis. Payment will be the lower of the usual and customary charge or the fee schedule. The fee schedule is the same as that used for mental health clinics (see State Plan ATTACHMENT 4.19-B, page 25) as these are comparable service providers.

T.N. # 98-10 Approval Date 12-2-98

Supersedes T.N. # New Effective Date 12-1-98

PAYMENT FOR CHIROPRACTIC SERVICES

Payments for chiropractic services are made based on encounter rates. There are two encounter rates; one for the initial evaluation and one for subsequent treatments.

T.N. # 93-34

Approval Date 12-13-93

Supersedes T.N. # New

Effective Date 10-1-93

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

PAYMENT FOR SERVICES

Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), are paid at the rates negotiated between the Health Care Financing Administration (HCFA) and the IHS and which are published in the Federal Register or Federal Register Notices.

T.N. # 00-07

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Supersedes T.N. # New

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