II. Physician Services

A. Definitions

(1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.

(2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.

(3) "Medical School Faculty Physician" is a physician who is employed by a state-supported school of medicine (for teaching and clinical responsibilities), receives their earnings statement (W-2) from the state-supported school of medicine for their teaching and clinical responsibilities, and they are part of a university health care system that includes:

(a) a teaching hospital; and
(b) a state-owned pediatric teaching hospital; or
(c) an affiliation agreement with a pediatric teaching hospital.

(4) Reimbursement for an anesthesia service shall include:

(a) Preoperative and postoperative visits;
(b) Administration of the anesthetic;
(c) Administration of fluids and blood incidental to the anesthesia or surgery;
(d) Postoperative pain management;
(e) Preoperative, intraoperative, and postoperative monitoring services; and
(f) Insertion of arterial and venous catheters.

B. Reimbursement

(1) Payment for covered physician services shall be based on the lesser of the physicians' usual and customary actual billed charges or the Medicaid Physician Fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician Services. The agency's fee schedule rate was set as of January 1, 2014 and is effective for services provided on or after that date and are updated annually on January 1st or thirty (30) days following the release of the revised CPT Codes from the American Medical Association, whichever is earlier. All rates are published on the agency's website at http://www.chfs.ky.gov/dms/fee.htm.

(2) If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be forty-five (45) percent of the billed charge. After the first quarter, Medicaid will establish a reimbursement rate based on the average payments for each procedure code during that quarter. The rate for that code will then be added to our Medicaid Physician Fee Schedule. If Medicare develops RBRVS Units for a procedure code, Kentucky will revise our Fee Schedule using the Medicare RBRVS Units

(3) The flat rate for a service shall be established by multiplying the dollar conversion factor by the sum of the RVU units plus the number of units spent on that specified procedure. RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

Types of Service	Kentucky Conversion Factor
Deliveries	Not applicable
Non-delivery Related Anesthesia	$15.20
Non-anesthesia Related Services	$29.67

C. Reimbursement Exceptions

(1) Physicians, who are enrolled in the Vaccines for Children (VFC) Program, will only be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the VFC Program to provide immunizations for Medicaid recipients under the age of nineteen (19). Vaccine costs for any VFC specified immunization will not be reimbursed for the physicians who are enrolled in the VFC Program. For additional information on vaccine administration, please see Att. 4.19-B, Page 20.5(4).

(2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Delivery only	$870.00
Vaginal delivery including postpartum care	$900.00
Cesarean delivery only	$870.00
Cesarean delivery including postpartum care	$900.00

(3) For delivery-related anesthesia services provided on or after July 1, 2006, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Vaginal delivery	$215.00
Cesarean section	$335.00
Neuroxial labor anesthesia for a vaginal delivery or cesarean section	$350.00
Additional anesthesia for cesarean delivery following neuroxial labor anesthesia for Vaginal delivery	$25.00
Additional anesthesia for cesarean hysterectomy following neuroxial labor Anesthesia	$25.00

(4) Payment for individuals eligible for coverage under Medicare part B is made, in accordance with Sections A and B and items (1) through

(5) Procedures which are specified by Medicare and published annually in the Federal Register, which are commonly performed in the physician's office, will be reimbursed adjusted rates to take into account the change in usual site of service (facility vs. non-facility based on Medicare Site of Service designation) and are subject to the outpatient upper payment limit.

(6) Payments for the injection procedure for chemonucleolysis of invertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or $793.50.

(7) Specified family planning procedures in the physician office setting shall be reimbursed at the lesser of the actual billed charges or the Medicaid Physician Fee Schedule plus actual cost of the supply minus ten percent.

(8) For information relating to physician injectable drug products that are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b).

(9) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).

(10) For practice related services 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 Medicaid Physician Fee Schedule per procedure

(11) Any physician participating in the lock-in program will be paid a $10.00 per month lock-in fee for provision of patient management services for each recipient locked in to that physician.

(12) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan to physicians that qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.

a. To qualify for a supplemental payment under this section, physicians must meet the following criteria:
   1. Be Kentucky licensed physicians;
   2. Be enrolled as Kentucky Medicaid providers; and
   3. Be Medical School Faculty Physicians as defined in Att 4.19-B, page 20.3, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.

b. For physicians qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between payments otherwise made to these physicians and the average rate paid for the services by commercial insurers. The payment amounts are determined by:
   1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the providers' contracted rates with commercial insurers for each procedure code from an actual year's data, beginning with CY 2006;
   2. Multiplying the total number of Medicaid claims paid per procedure code by the average commercial payment rate for each procedure code to establish the estimated commercial payments to be made for these services; and
   3. Subtracting the initial fee-for-service Medicaid payments, all Medicare payments, and all Third Party Liability payments already made for these services to establish the supplemental payment amount. Effective January 1, 2007 all claims, where Medicare is the primary provider, will be excluded from the supplemental payment methodology.
   4. The supplemental payments will be calculated annually after the end of each CY using actual data from the most recent completed CY. Claims data will only be used for physicians meeting the criteria in Part (a) above. If a physician did not meet the criteria for the whole calendar year, then only the claims data that coincides with their dates of eligibility will be used in the calculation. The supplemental payments will not be increased with any trending or inflationary indexes.

c. Initial fee-for-service payments under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made as four (4) equal quarterly payments.

(13) 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

(14) If more than one procedure is performed at the same time, the provider shall be reimbursed one hundred (100) percent of the Medicaid Physician Fee Schedule for the first procedure and fifty (50) percent of the Medicaid Physician Fee Schedule for each additional procedure.

(15) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) or over age seventy (70).

(16) Physicians, who are not enrolled in the VFC Program, will be reimbursed for the administration of immunizations, to include the influenza vaccine, as well as the vaccine cost, as defined in the Center for Disease Control (CDC) Vaccine Price List published as of January 1, 2014 to a Medicaid recipient of any age.

(17) After Hours Services - CPT 99050 is reported when services are provided in the office at times other than regularly scheduled office hours or days when the office is normally closed. DMS refers to this time as "After Hours," and defines "After Hours" as services rendered between 5:00 p.m. and 8:00 a.m. on weekdays, and anytime on weekends and holidays when the office is usually closed. For example – if normal office hours are scheduled from 9:00 – 5:00 and service is provided at 7:00, the provider would bill CPT 99050. However, if normal office hours are scheduled from 9:00 am – 7:00 pm and the service is performed at 6:00, the provider would NOT bill for CPT code 99050.

CPT code 99050 is eligible for separate payment, in addition to the basic covered service, if the basic service provided meets all of the criteria described below:

- It is reported with an office setting place of service;
- It is rendered after hours; and
- The basic service time is based on arrival time, not actual time services commence.

CPT code 99050 is not eligible for separate payment when it is reported with a preventive diagnosis and/or a preventive service.

Effective for services provided on or after January 1, 2015, payment for CPT Code 99050 will be $25.00

(18) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of $150.

(19) For an evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit outlined in Att. 3.1-A p. 7.2.1 & Att. 3.1-B p. 21, DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.

(20) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 will be reimbursed at eighty-seven and one half (87.5) percent of Medicare Fee Schedule in effect as of January 1, 2006.

(21) For reimbursement for eligible services provided by a physician or a physician assistant at a Community Mental Health Center - please refer to Attachment 4.19-B, Page 20.15 - 20.15(1)(a)(viii)

D. Assurances. The State hereby assures that payment for physician services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.

E. Ambulance Response and Treat-no-transport Services:

Effective for dates of service on or after January 1, 2024, ambulance providers will be reimbursed for appropriate and medically necessary medical care when an ambulance is dispatched, and treatment is provided to the patient without the patient being transported to another site. Reimbursement for treatment-no-transport will be made for Healthcare Common Procedure Coding System (HCPCS) code A0998 at the Kentucky Medicaid Transportation fee schedule rate for Current Procedural Terminology (CPT) code A0429 (BLS base, hospital). No additional mileage rate will be paid.

All rates are published on the agency's website at https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx

Physician Services - Wellness Incentive

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each CPT Code the State has included in the Enhanced Wellness Fee Schedule.

Primary Care Services Affected by this Payment Methodology

☒ This payment applies to all billing codes listed below. Multiple services performed on the same day by the same provider will be processed using Modifier 1 and Modifier 2. Multiple enhanced payments may be paid for same day/same provider up to the Medicare Allowed Amount for the CPT Code listed. The State has included quantity limits that apply to the number of enhanced payments a provider will receive per year for each CPT code listed.

Providers Eligible for Enhanced Wellness Methodology

Provider Type 64 and 65, including all specialties and subspecialties and Provider Type 78 (APRN) and 95 (Physician Assistant) are eligible for the enhanced Wellness reimbursement.

Physician Services - Wellness Incentive (cont.)

Primary Care Services Affected by this Payment Methodology

The Wellness Enhanced Rate is the lesser of the modified rate and the 2014 Medicare Rate.

Modifier Descriptions	
33/U5 identifies vaccine administration	33/UA identifies well child visits first 15 months of life
33/U7 identifies screenings	33/UB identifies BMI/Weight Counseling
33/U8 identifies after hours	33/UD identifies controlling BP

Bonus Fee Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description
90460	33	U5	$0.00	$3.30	$12.00	$15.30	$15.30	Modified Rate
90471	33	U5	$0.00	$3.30	$12.00	$15.30	$15.30	Modified Rate
90472	33	U5	$0.00	$3.30	$10.00	$13.30	$13.30	Modified Rate
90473	33	U5	$0.00	$3.30	$12.00	$15.30	$15.30	Modified Rate
90474	33	U5	$0.00	$3.30	$10.00	$13.30	$13.30	Modified Rate
83655	33	U7	$0.00	$17.13	$16.00	$33.13	$33.13	Modified Rate
99381	33	UA	$103.36	$78.58	$16.00	$94.58	$94.58	Modified Rate
99382	33	UA	$107.92	$89.90	$16.00	$105.90	$105.90	Modified Rate
99391	33	UA	$93.12	$67.57	$16.00	$83.57	$83.57	Modified Rate
99392	33	UA	$99.61	$78.58	$16.00	$94.58	$94.58	Modified Rate
99461	33	UA	$91.40	$75.36	$16.00	$91.36	$91.36	Modified Rate
99201	33	UA	$39.86	$29.66	$16.00	$45.66	$39.86	Medicare Rate
99202	33	UA	$68.99	$53.00	$16.00	$69.00	$68.99	Medicare Rate
99203	33	UA	$100.39	$79.04	$16.00	$95.04	$95.04	Modified Rate
99204	33	UA	$155.31	$112.27	$16.00	$128.27	$128.27	Modified Rate
99205	33	UA	$194.18	$143.29	$16.00	$159.29	$159.29	Modified Rate
99211	33	UA	$18.28	$16.98	$16.00	$32.98	$18.28	Medicare Rate
99212	33	UA	$40.17	$31.08	$16.00	$47.08	$40.17	Medicare Rate
99213	33	UA	$67.93	$42.63	$16.00	$58.63	$58.63	Modified Rate
99214	33	UA	$100.55	$67.10	$16.00	$83.10	$83.10	Modified Rate
99215	33	UA	$135.11	$98.39	$16.00	$114.39	$114.39	Modified Rate
77055	33	U7	$81.75	$56.43	$17.00	$73.43	$73.43	Modified Rate
77056	33	U7	$104.99	$70.46	$17.00	$87.46	$87.46	Modified Rate
77057	33	U7	$75.19	$58.97	$17.00	$75.97	$75.19	Medicare Rate

Physician Services - Wellness Incentive (cont.)

Bonus Fee Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description
G0202	33	U7	$120.80	$91.56	$17.00	$108.56	$108.56	Modified Rate
G0204	33	U7	$147.47	$99.65	$17.00	$116.65	$116.65	Modified Rate
G0206	33	U7	$116.11	$80.34	$17.00	$97.34	$97.34	Modified Rate
88141	33	U7	$29.62	$18.02	$13.00	$31.02	$29.62	Medicare Rate
88142	33	U7	$0.00	$27.64	$13.00	$40.64	$40.64	Modified Rate
88143	33	U7	$0.00	$27.64	$13.00	$40.64	$40.64	Modified Rate
88147	33	U7	$0.00	$14.42	$13.00	$27.42	$27.42	Modified Rate
88148	33	U7	$0.00	$14.42	$13.00	$27.42	$27.42	Modified Rate
88150	33	U7	$0.00	$14.42	$13.00	$27.42	$27.42	Modified Rate
88160	33	U7	$58.45	$36.56	$13.00	$49.56	$49.56	Modified Rate
88161	33	U7	$53.45	$36.81	$13.00	$49.81	$49.81	Modified Rate
88162	33	U7	$87.37	$45.06	$13.00	$58.06	$58.06	Modified Rate
G0123	33	U7	$0.00	$27.64	$13.00	$40.64	$40.64	Modified Rate
G0144	33	U7	$0.00	$29.15	$13.00	$42.15	$42.15	Modified Rate
G0145	33	U7	$0.00	$35.04	$13.00	$48.04	$48.04	Modified Rate
P3000	33	U7	$0.00	$14.42	$13.00	$27.42	$27.42	Modified Rate
Q0091	33	U7	$40.64	$33.66	$13.00	$46.66	$40.64	Medicare Rate
44388	33	U7	$322.86	$191.73	$15.00	$206.73	$206.73	Modified Rate
44389	33	U7	$362.87	$210.07	$15.00	$225.07	$225.07	Modified Rate
44391	33	U7	$457.41	$280.73	$15.00	$295.73	$295.73	Modified Rate
44392	33	U7	$404.58	$267.50	$15.00	$282.50	$282.50	Modified Rate
44394	33	U7	$457.15	$285.40	$15.00	$300.40	$300.40	Modified Rate
45330	33	U7	$124.52	$64.08	$15.00	$79.08	$79.08	Modified Rate
45331	33	U7	$148.99	$83.80	$15.00	$98.80	$98.80	Modified Rate
45332	33	U7	$265.56	$108.61	$15.00	$123.61	$123.61	Modified Rate
45341	33	U7	$150.29	$148.42	$15.00	$163.42	$150.29	Medicare Rate
45342	33	U7	$228.98	$171.39	$15.00	$186.39	$186.39	Modified Rate
45345	33	U7	$167.48	$142.59	$15.00	$157.59	$157.59	Modified Rate
45355	33	U7	$198.12	$137.10	$15.00	$152.10	$152.10	Modified Rate
45378	33	U7	$359.50	$228.82	$15.00	$243.82	$243.82	Modified Rate
45379	33	U7	$461.67	$292.40	$15.00	$307.40	$307.40	Modified Rate
45380	33	U7	$428.21	$255.86	$15.00	$270.86	$270.86	Modified Rate
45381	33	U7	$428.82	$284.36	$15.00	$299.36	$299.36	Modified Rate
45382	33	U7	$556.15	$335.55	$15.00	$350.55	$350.55	Modified Rate

Physician Services - Wellness Incentive (cont.)

Bonus Fee Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description
45383	33	U7	$522.37	$343.18	$15.00	$358.18	$358.18	Modified Rate
45386	33	U7	$607.98	$530.14	$15.00	$545.14	$545.14	Modified Rate
45387	33	U7	$332.42	$232.95	$15.00	$247.95	$247.95	Modified Rate
45391	33	U7	$283.59	$212.17	$15.00	$227.17	$227.17	Modified Rate
45392	33	U7	$364.54	$268.20	$15.00	$283.20	$283.20	Modified Rate
82270	33	U7	$0.00	$4.44	$15.00	$19.44	$19.44	Modified Rate
82274	33	U7	$0.00	$21.70	$15.00	$36.70	$36.70	Modified Rate
G0105	33	U7	$359.50	$255.86	$15.00	$270.86	$270.86	Modified Rate
G0121	33	U7	$359.50	$297.76	$15.00	$312.76	$312.76	Modified Rate
G0328	33	U7	$0.00	$21.70	$15.00	$36.70	$36.70	Modified Rate
99050	33	U8	$0.00	$10.00	$15.00	$25.00	$25.00	Modified Rate
94010	33	U7	$32.26	$24.44	$12.00	$36.44	$32.26	Medicare Rate
94014	33	U7	$47.92	$12.62	$12.00	$24.62	$24.62	Modified Rate
94016	33	U7	$24.53	$4.89	$12.00	$16.89	$16.89	Modified Rate
94060	33	U7	$54.27	$45.35	$12.00	$57.35	$54.27	Medicare Rate
94375	33	U7	$35.71	$28.04	$12.00	$40.04	$35.71	Medicare Rate
99201	33	UB	$39.86	$29.66	$10.00	$39.66	$39.66	Modified Rate
99202	33	UB	$68.99	$53.00	$10.00	$63.00	$63.00	Modified Rate
99203	33	UB	$100.39	$79.04	$10.00	$89.04	$89.04	Modified Rate
99204	33	UB	$155.31	$112.27	$10.00	$122.27	$122.27	Modified Rate
99211	33	UB	$18.28	$16.98	$10.00	$26.98	$18.28	Medicare Rate
99212	33	UB	$40.17	$31.08	$10.00	$41.08	$40.17	Medicare Rate
99213	33	UB	$67.93	$42.63	$10.00	$52.63	$52.63	Modified Rate
99214	33	UB	$100.55	$67.10	$10.00	$77.10	$77.10	Modified Rate
99215	33	UB	$135.11	$98.39	$10.00	$108.39	$108.39	Modified Rate
99382	33	UB	$107.92	$89.90	$10.00	$99.90	$99.90	Modified Rate
99383	33	UB	$112.71	$89.90	$10.00	$99.90	$99.90	Modified Rate
99384	33	UB	$127.76	$101.22	$10.00	$111.22	$111.22	Modified Rate
99385	33	UB	$123.96	$95.21	$10.00	$105.21	$105.21	Modified Rate
99386	33	UB	$143.58	$116.70	$10.00	$126.70	$126.70	Modified Rate
99387	33	UB	$155.84	$127.40	$10.00	$137.40	$137.40	Modified Rate
99392	33	UB	$99.61	$78.58	$10.00	$88.58	$88.58	Modified Rate
99393	33	UB	$99.30	$78.58	$10.00	$88.58	$88.58	Modified Rate

Physician Services - Wellness Incentive (cont.)

Bonus Fee Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description
99394	33	UB	$108.97	$89.90	$10.00	$99.90	$99.90	Modified Rate
99395	33	UB	$111.38	$84.80	$10.00	$94.80	$94.80	Modified Rate
99396	33	UB	$118.91	$100.83	$10.00	$110.83	$110.83	Modified Rate
99397	33	UB	$127.76	$106.26	$10.00	$116.26	$116.26	Modified Rate
99201	33	UD	$39.86	$29.66	$16.00	$45.66	$39.86	Medicare Rate
99202	33	UD	$68.99	$53.00	$16.00	$69.00	$68.99	Medicare Rate
99203	33	UD	$100.39	$79.04	$16.00	$95.04	$95.04	Modified Rate
99204	33	UD	$155.31	$112.27	$16.00	$128.27	$128.27	Modified Rate
99205	33	UD	$194.18	$143.29	$16.00	$159.29	$159.29	Modified Rate
99211	33	UD	$18.28	$16.98	$16.00	$32.98	$18.28	Medicare Rate
99212	33	UD	$40.17	$31.08	$16.00	$47.08	$40.17	Medicare Rate
99213	33	UD	$67.93	$42.63	$16.00	$58.63	$58.63	Modified Rate
99214	33	UD	$100.55	$67.10	$16.00	$83.10	$83.10	Modified Rate
99215	33	UD	$135.11	$98.39	$16.00	$114.39	$114.39	Modified Rate
99241	33	UD	$45.48	$36.55	$16.00	$52.55	$45.48	Medicare Rate
99242	33	UD	$85.97	$67.83	$16.00	$83.83	$83.83	Modified Rate
99243	33	UD	$117.67	$90.43	$16.00	$106.43	$106.43	Modified Rate
99245	33	UD	$214.66	$166.18	$16.00	$182.18	$182.18	Modified Rate
99386	33	UD	$143.58	$116.70	$16.00	$132.70	$132.70	Modified Rate
99387	33	UD	$155.84	$127.40	$16.00	$143.40	$143.40	Modified Rate
99394	33	UD	$108.97	$89.90	$16.00	$105.90	$105.90	Modified Rate
99395	33	UD	$111.38	$84.80	$16.00	$100.80	$100.80	Modified Rate
99396	33	UD	$118.91	$100.83	$16.00	$116.83	$116.83	Modified Rate
99397	33	UD	$127.76	$106.26	$16.00	$122.26	$122.26	Modified Rate

Physician Services - Wellness Incentive (cont.)

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2015, ending on June 30, 2016. All rates are published at http://chfs.ky.gov/dms/fee.htm.