The Secretary for Health Services
COMMONWEALTH OF KENTUCKY
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PAUL E. PATTON
GOVERNOR

MARCIA R. MORGAN
SECRETARY

November 3, 2003

Physician Letter #A-344

Dear Provider:

This letter is being sent to notify you of upcoming policy revisions affecting services provided to Medicaid recipients by physicians. Proposed revisions to 907 KAR 3:005, Physicians' Services and 907 KAR 3:010, Reimbursement for Physicians' Services are expected to go into effect December 17, 2003. Following that date, copies of the updated regulations will be available on our web-site at http://www.chs.ky.gov/dms/.

Revisions to these regulations are necessary to ensure compliance with provisions adopted in related program regulations in reference to recipient co-payment obligations and Medicare crossover claim payments and federal regulations mandating protection of the confidentiality of personal medical information. Other areas in which amendments have been made include:

- Coverage of prior authorized allergy injections for children under age 21;
- Coverage of procedures designated by a modifier identifying a location on the body;
- Services requiring prior authorization as a condition of coverage;
- Billing of a service provided by a physician assistant;
- Reimbursement of a multiple birth delivery;
- Reimbursement methodology for an unlisted procedure; and
- Reimbursement methodology for anesthesia services.

A series of workshops will be conducted to clarify how the new policies will affect existing coverage critieria and billing procedures. These workshops will be offered December 2nd and 4th in the Human Services Building Auditorium, 275 East Main Street,

Frankfort, Ky. To maximize availability of workshop participation to all who may be interested, a 9:30 morning session and a 1:00 afternoon session will be offered both days. Each physician practice is encouraged to send a representative to one of the workshop sessions to have questions addressed and obtain updated billing instructions.

Your continued participation in the Medicaid Physicians' Program is very important to this agency and the citizens of the Commonwealth. If you have questions or concerns regarding Physician Program policy, please do not hesitate to contact Duane Dringenburg of the Physicians and Specialty Services Division at 502-564-3477.

Sincerely,

Marcia R. Morgan

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Secretary

MRM/dd/clj

POLICY CHANGES SUMMARY

1. Require Prior Authorization for services now listed with "R" on fee schedule S-10
   These services include "unlisted" procedures, any that could be considered cosmetic, and those requiring Federal consent forms.
   NHS will perform prior authorization. For information call 1 800-292-2392 –effective Jan 1,2004

2. Allergy injections are now cover through physician provider number but **require PA** S 10
   These formerly required provider to enroll for a EPSDT provider number
   Unsure on transition will give info later on how old PA's with EPSDT #'s will be handled.
   K-Chip III will now be eligible

3. Require Physician Assistants to obtain provider number and link to physician supervisor. S 11
   All physician assistant services billed to DMS will require the PA to be enrolled and linked
   Forms are available from Unisys by call 1-877-838-5085.
   A letter was sent to provider with this information last month.

4. Reimbursement for codes without rates changes to 45% R 5
   This is consistent with all other DMS programs.
   These will also require prior authorization.
   Only rarely accept "unlisted" code. Most services without codes are considered experimental and not covered.

5. Co-pay required only on 92002, 92004, 92012, 92014 could change if regulation does R 5
   The regulation effecting co-pay is 907 KAR 1:604, it is only referenced in this regulation
   4 vision codes only

6. HCPC Level II modifiers required on appropriate codes R 6
   These modifiers are listed in the front of the CPT codebook and reference the parts of the body.
   The list of modifiers valid for the physician program on page 3.29

7. Limitation removed from vaccines R 7
   Previously there was a limit of 3 per date of service.
   All other previous criteria apply.
   Only physicians

8. Anesthesia conversion factor increased to $29.67. Anesthesia "add-on-Code" 99100 for age R 7, 8
   The conversion factor for anesthesia previously had been $29.02
   Physician rates are calculated from the RBRVS which is the RVU multiplied by the KY conversion factor. The rates are published on the Medicaid website and available from provider enrollment for those without Internet access.

9. J codes now paying Average Wholesale Price minus 12% R 8
   This is consistent with the Pharmacy Regulation. Physician Program uses the annual Redbook for determining the AWP and normally update in January.
   There has been no change in the J-codes that are covered.

10. Upper level E&M codes in excess of 1 per year, rate reduced R 9
    Example: If the cpt code 99214 or 99215 would be billed a second time in 12 months In the past the claim would deny, now it will pay at the rate for CPT code 99213

11. Changes on Twin delivery both vaginal and c-section R11
    If a delivery of twins results in one being delivered vaginally and one c-section, it will Pay 100% of the c-section delivery and 50% of the vaginal delivery. Twins delivered by same method is considered one delivery.
    Only pay one unit because one mother

12. Clarification of global surgery and consultation R 10
    This is not a change it is just a clarification of DMS policy stating consultations etc Are included in the global payment for the surgery.
    Codes that are considered global, incidental, mutually exclusive etc are not billable to recipient

NOTE ON BILLING NEWBORN SERVICES:
The only procedure codes for baby that may be billed under the mother's provider number are: 99431,99432, 99433, 99435, 54150 or 54160

R = Reimbursement Regulation
S = Services Regulation