5. Physicians' Services (Continued)

**Additional Reimbursement for Physician Services Associated with UAMS**

**Effective October 1, 2002, professional services provided by medical professional providers affiliated with the University of Arkansas for Medical Sciences (UAMS) to Medicaid-eligible individuals shall be reimbursed based on the average commercial payment rate. Eligible professionals shall include physicians and other health care professionals, including UAMS professionals affiliated with the College of Medicine and UAMS professionals providing services at Area Health Education Centers.**

**Eligible professionals shall be paid a base amount according to otherwise applicable provisions of this State Plan. A supplemental adjustment shall be paid on a monthly basis equal to the difference between a prospectively determined specified percentage (average commercial payment rate) of total Medicaid charges and Medicaid reimbursement otherwise received. The amount of monthly payment shall be determined as follows:**

**(1) Before the beginning of the state fiscal year, total payable amounts for services provided by eligible professionals shall be determined by adding all payments by commercial insurance carriers in the most recently completed fiscal year to amounts payable by patients (co-payments and deductibles) insured by those carriers in that year. Commercial insurance carriers shall include preferred provider organizations (PPOs), Blue Shield and all other commercial carriers.**

**(2) The total payable amounts shall be divided by total commercial charges to determine the average commercial payment rate for the upcoming fiscal year.**

**(3) At the end of each month throughout the year, the amount of paid Medicaid charges for eligible providers for the previous month shall be multiplied by the specified percentage to determine a commercial equivalent amount for that month.**

**(4) Medicaid payments, including cash received plus accrued amounts, made to eligible providers during the previous month shall be subtracted from the commercial equivalent amount to determine the monthly supplemental payment.**

**The average commercial payment rate shall be determined prospectively based on data from the UAMS' accounts receivable system from the most recently completed State fiscal year. The monthly supplemental payments shall be final, subject to adjustments made for those charges associated with patients later found to be ineligible. Charges for clinical services will be the same for all payers.**

6. Medical Care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.

a. Podiatrists' Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. The Title XIX maximum is 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

**Additional Reimbursement for Podiatrists' Services Associated with UAMS**

**Refer to Attachment 4.19-B, item 5.**

6. Medical Care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.

b. Optometrist's Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum allowed. Effective for claims with dates of services on or after March 1, 1997, the Title XIX (Medicaid) maximum reimbursement for optometrist services is the same as the physician rates for applicable services.

c. Chiropractors' Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.

Effective for dates of service on or after June 1, 1998, the current Arkansas Medicaid maximum of $23.58 for procedure code A2000 (Manipulation of the Spine by Chiropractor) will be used to establish the reimbursement rate for each CPT procedure code for Chiropractic care. This care will be covered as described in the following procedure codes established by the American Medical Association (AMA) and published in their 1997 Physician=s Current Procedural Terminology (CPT) Manual, or such procedure codes as AMA (or it=s successor) shall declare are replacements for, and successor= to the following:

98940 Chiropractic manipulative treatment (CMT); spinal, one to two
98941 Chiropractic manipulative treatment (CMT); spinal, three of four regions
98942 Chiropractic manipulative treatment (CMT); spinal, five regions

Effective for dates of service on or after July 1 of each year, Arkansas Medicaid will apply an adjustment factor to the Medicaid maximum. To determine the adjustment factor, a comparison between the previous and current year=s Medicare rates will be made. The adjustment factor will be equal to the average adjustment made to the Medicare payment rates for all of the above CPT procedure codes as reflected in the current Medicare Physician=s Fee Schedule.

d. Other Practitioners' Services

(l) Hearing Aid Dealers - Refer to Attachment 4.19-B, Item 4.b. (10).
(2) Audiologist - Refer to Attachment 4.19-B, Item 4.b. (11).
(3) Optical Labs - Based on contract price. Established through competitive bidding.
(4) Nurse Anesthetists - Reimbursement is based on 80% of the Medicaid Physician Fee Schedule.

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

6.d. Other Practitioner's Services (Continued)

(5) Psychologist Services

Refer to Attachment 4.19-B, Item 4.b. (17).

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

(6) Obstetric-Gynecologic and Gerontological Nurse Practitioner Services

Reimbursement is the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is based on 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the nurse practitioner and physician.

Refer to Attachment 4.19-B, Item 27, for a list of the nurse practitioner pediatric and obstetrical procedure codes.

**(7) Advanced Practice Nurses Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.**

**(8) Licensed Clinical Social Workers' Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.**

**(9) Physicians' Assistant Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.**

7. Home Health Services

a. Intermittent or part-time nursing services furnished by a home health agency or a registered nurse when no home health agency exists in the area; and

b. Home health aide services provided by a home health agency

Reimbursement on basis of amount billed not to exceed the Title XIX (Medicaid) maximum.

The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a. and b. was established by dividing total allowable costs by total visits. This figure was then inflated by the Home Health Market Basket Index in Federal Register #129, Vol. 58 dated July 8, 1993- inflation factors: 1991 - 105.7%, 1992 - 104.1%, 1993 - 104.8%. The inflated cost per visit was then weighted by the total visits per providers' fiscal year (i.e., the visits reported on the 1990 Medicare cost reports) to arrive at a weighted average visit cost.

16. Inpatient Psychiatric Facility Services For Individuals Under 22 Years of Age (Continued)

Sexual Offender Programs (continued)

New providers are required to submit a full year=s annual budget for the current State Fiscal Year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the upper limit (cap).

Year-end cost reports must be submitted and will be audited in the same manner as audits for inpatient psychiatric hospital Residential Treatment Units (RTUs) and will be cost settled.

Interim rates and cost settlements are calculated using the same methodology as inpatient residential treatment units with the same professional component cap and the same annual State Fiscal year per diem cap.

17. Nurse Midwife Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum. The Title XIX Maximum for nurse-midwife services is based on 80% of the current physician Medicaid Maximum. Rhogam RhoD Immune Globulin is reimbursed at the same rate as the physician's rate since the cost and administration of the drug does not vary between the nurse midwife and physician.

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