

**907 KAR 11:035. Payments for early and periodic screening, diagnosis, and treatment services and early and periodic screening, diagnosis, and treatment special services.**

RELATES TO: KRS 205.520, 605.115, 42 C.F.R. 440.40(b), 441.50-441.62, 447.201-447.205, 42 U.S.C. 1396a, b, d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of Medicaid to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining amounts payable by the Department for Medicaid Services for early and periodic screening, diagnosis, and treatment services and early and periodic screening, diagnosis, and treatment special services.

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designated agent.

(2) "EPSDT" means early and periodic screening, diagnosis, and treatment in accordance with 42 C.F.R. 440.40(b), 441.56(b)-(c), 441.57, and 441.58.

(3) "EPSDT special services" means a service that is:

(a) Allowable under 42 C.F.R. 441.50 through 441.62 and 42 U.S.C. 1396d(r);

(b) Not otherwise covered under the Kentucky Medicaid Program; and

(c) Medically necessary in accordance with 907 KAR 3:130 to correct or ameliorate a defect, physical or mental illness, or condition of a recipient.

(4) "Medicaid physician fee schedule" means a list of current reimbursement rates for physician services established in accordance with 907 KAR 3:010, Section 3(1).

(5) "Recipient" means a Medicaid eligible individual under the age of twenty-one (21), which includes the month in which the child becomes twenty-one (21).

(6) "Usual and customary charge" means the uniform amount a physician charges to the general public for a specific medical procedure or service.

Section 2. Reimbursement. (1) A provider shall be reimbursed for a screening service in accordance with the payment provisions established through the appropriate Medicaid provider program.

(2) Payment for a screening service provided by an EPSDT enrolled screening clinic shall be the amount specified in the Medicaid physician fee schedule for the procedure code.

(3) Payment for a screening service shall not exceed the usual and customary charge of the provider for the service.

Section 3. Reimbursement of EPSDT Diagnosis and Treatment Providers. The department shall reimburse an EPSDT diagnosis or treatment provider participating in compliance with 907 KAR 1:034, Section 8(1) as specified in 907 KAR Chapters 1 and 3 for reimbursement for the particular diagnosis or treatment service rendered.

Section 4. Reimbursement of EPSDT Special Services Providers. (1) Except as specified in Section 5 of this administrative regulation, the department shall reimburse for an EPSDT special service which is similar to a service covered in another Medicaid Program based on the payment methodology established for that provider program.

(2) Reimbursement for a special service that does not have a reimbursement rate established under subsection (1) of this section shall be based on a fee negotiated by the department adequate to obtain the service.

(3) The negotiated fee shall not exceed 100 percent of the usual and customary charges.

(4) If the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits.

(5) If an EPSDT special service is provided before prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.

Section 5. Reimbursement of School-based Health Services Providers. (1) The department shall reimburse a school-based health service provider for a service included in an individualized education program which is provided to a Medicaid eligible recipient based on a fee-for-service system designed to approximate cost for all participating providers in the aggregate without settlement to exact cost.

(2) Payment rates for a service shall be established using the following methodology:

(a) Interim payment rates for a service shall be based on annual cost data submitted in accordance with paragraph (b) of this subsection for the previous state fiscal year and shall be adjusted up or down as appropriate when final payment rates are established.

(b) Final payment rates shall be set based on the following:

1. Except as specified in subparagraphs 4 and 5 of this paragraph, a payment rate for a particular service shall be based on the lower of the mean or median of the participating providers' cost of providing the service;

a. The statewide mean and median cost for a service shall be based on the contracted hourly service cost and the cost associated with publicly employed professionals; and

b. The mean and median hourly cost shall be calculated, for each class of qualified professionals, from an array of hourly cost data falling within one (1) standard deviation of the mean;

2. Cost for publicly employed professionals shall be computed in the following manner:

a. Salary, fringe benefits, and indirect overhead shall be included;

b. Annual professional salaries (including full time equivalent employees) shall be converted to hourly wages using 185 work days per year and six (6) work hours per day;

c. The applicable fringe benefit cost based on the actual percentage rate for classified and certified employees shall be added to the hourly salary wage; and

d. An indirect overhead cost consisting of seven (7) percent of the hourly wage shall be added to the hourly salary wage;

3. Payments for a professional service shall be based on units of service which are fifteen (15) minute increments;

4. Payments for medical transportation provided in accordance with 907 KAR 1:715, Section 3, shall be based on the average cost per mile of pupil transportation as calculated by the Department of Education;

5. Payments for assistive technology and medical equipment provided in accordance with 907 KAR 1:715, Section 3, shall be based on actual invoiced cost including cost, of shipping and handling, for the authorized equipment included in an individualized education program;

6. For each school year ending June 30, final payment rates shall be set using corresponding cost data available as of September 1 for that school year; and

7. Final payment rates shall be the lower of the billed charge or the Medicaid rate on file for the date the service is provided;

(c)1. A school based health services provider shall submit annual cost data to the department no later than August 31 of each year; and

2. If the cost data is not submitted within the specified period, the school-based health services

provider shall be terminated from the program; and

(d) A school-based health services provider shall certify quarterly expenditures of state or local funds used to provide covered school-based health services to Medicaid-eligible children as specified in 702 KAR 3:285. (2 Ky.R. 109; eff. 9-10-1975; 5 Ky.R. 64; eff. 9-6-1978; 7 Ky.R. 410; eff. 12-3-1980; Recodified from 904 KAR 1:035, 5-2-1986; Ky.R. 1623; eff. 1-10-1992; 23 Ky.R. 1799; eff. 12-18-1996; 25 Ky.R. 933; 1382; eff. 12-16-1998; 30 Ky.R. 1859; 2035; eff. 3-18-2004; Recodified from 907 KAR 1:035; eff. 5-3-2011; Crt eff. 12-6-2019.)