CHAPTER 600–REIMBURSEMENT METHODOLOGIES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 615	CPT/HCPCS National Level Code Updates	12/16/05	01/01/06
Section 620	Third Party Liability	11/28/05	01/01/06
Section 640.16	Physician Services	07/18/05	Clarification of current policy
Sections620, 640.15, 640.16	Various	12/02/04	01/01/05
Section620	Third Party Liability	12/02/04	01/01/05
Section 630.2	Payment Recoveries	12/02/04	01/01/05
Section 640.15	Pharmacy Services	12/02/04	01/01/05

December 16, 2005

Section 615

Introduction: Effective 1/1/06, Medicaid will adopt the new 2006 National level 1 (CPT), and II (HCPCS) code updates. Covered procedures or services that were deleted by CMS 12/31/05, will be replaced with the appropriate National 2006 Code. Any procedure or service billed to Medicaid must be billed to Medicaid using the National Level I or II code. Permanent National codes will be used by Medicaid rather than the temporary codes. ***Please note that not all 2006 codes may be covered automatically by Medicaid.**

For non-covered services (NC), refer to the RBRVS file, or the applicable manual, etc., DME, J-Q code listing will be posted on the Bureau's web page at www.wvdhhr.org/bms. This notification will also appear on the Bureau's web page, as well as the banner pages of remittance vouchers.

Change: Inserting National Level Codes – CPT/HCPCS for 2006.

Directions: Replace all affected pages of current manual.

November 28, 2005

Section 620

Introduction: Revisions being made to reflect the change in Prior Authorizations requirements.

Change: Change the last sentence in the third paragraph to read as follows: Medicaid will then reimburse the lesser amount of the remainder of an approved claim up to the Medicaid allowable amount or the co-insurance and/or deductible amount.

Add the following statements as two new paragraphs after the third paragraph in each section:

Medicaid covered services which currently require a prior authorization (PA) from the BMS Utilization Management Contractor (UMC) will no longer need a UMC PA if a primary insurance approves that service. An approved service has one of the following listed on the explanation of benefits (EOB): allowed amount, deductible amount, co-insurance amount or payment amount. The EOB must accompany the invoice. If the service is not allowed by the primary insurance, but is a covered service for Medicaid and the service requires a PA from the UMC, Medicaid policy will be enforced.

Orthodontic and periodontic services will still require a Medicaid prior authorization from the UMC, when applicable, regardless of primary insurance requirements.

Directions: Replace all affected pages of current manual.

October 25, 2005

***Note: The changes noted in Section 620, Third Party Liability, of the manual have been effective since 1/01/05; however, due to a technological problem that occurred in July 2005, the manual contents reverted back to the content prior to the 1/01/05 effective date.**

July 18, 2005

Section 640.16

Introduction: Confusion has arisen from the example conversion factor calculation listed in the anesthesiology area of this section. The conversion rate shown is only an example, not the current conversion factor.

Change: Under *Anesthesiology*, added the wording “An example follows:” to clarify that the figures listed are only examples.

Directions: Replace the pages containing these sections.

December 2, 2004

Sections 620, 640.15, 640.16

Introduction: The terms beneficiary and recipient have been replaced by member throughout the entire manual.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 620

Introduction: Changed methodology since conversion of Unisys.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 630.2

Introduction: The Office of Audits, Research, and Analysis has been changed.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

Section 640.15

Introduction: Wording change to match Chapter 518 of the Pharmacy Services Manual.

Directions: Replace the page containing this section.

Change: Replace current section with the updated one.

CHAPTER 600—REIMBURSEMENT METHODOLOGIES

TABLE OF CONTENTS

TOPIC **PAGE NO.**

CHAPTER 600–REIMBURSEMENT METHODOLOGIES

600 INTRODUCTION

This chapter provides an overview of various types of reimbursement methodologies utilized by the Bureau for Medical Services (BMS) to reimburse providers for West Virginia (WV) Covered Medicaid services. Information is also provided regarding Medicaid as a secondary payer, and Medicaid's relationship to Medicare.

610 DIAGNOSIS RELATED GROUPS (DRG)

"Diagnosis Related Groups (DRG)" is a classification system that groups patient services according to diagnosis, type of treatment, age, and other relevant criteria, and is widely used for reimbursement of inpatient services. All acute care hospitals are reimbursed using DRG methodology. It is a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual. The DRGs are reviewed and recalculated annually using adjustment/severity factors applicable to certain types of admissions.

611 RESOURCE BASED RELATIVE VALUE SCALE (RBRVS)

The West Virginia Medicaid Program administered by the Bureau For Medical Services, West Virginia Department of Health and Human Resources (DHHR), together with the Public Employees Insurance Agency and the Worker's Compensation Fund of the Bureau of Employment Programs implemented a common payment system for reimbursement of physician and other practitioner services based on a modified version of the Resource Based Relative Value Scale (RBRVS) adopted by the Medicare Program. To the extent their services are covered by West Virginia Medicaid, the following types of providers are reimbursed under the RBRVS fee schedule:

- Physicians (including doctors of medicine and osteopathy and Physician Assistants working under their supervision)
- Limited licensed practitioners (including doctors of optometry, podiatry, dental surgery and dental medicine: oral and maxillofacial surgery and chiropractors)
- Independently practicing Physical Therapists and Occupational Therapists (when providing outpatient services only)
- Suppliers of the technical component of radiology or diagnostic services
- Family and Pediatric Nurse Practitioners
- Nurse Midwives
- Certified Registered Nurse Anesthetists.

615 CPT/HCPCS NATIONAL LEVEL CODE UPDATES

Effective 1/1/06, Medicaid will adopt the new 2006 National level 1 (CPT), and II (HCPCS) code updates. Covered procedures or services that were deleted by CMS 12/31/05, will be replaced with the appropriate National 2006 Code. Any procedure or service billed to Medicaid must be billed to Medicaid using the National Level I or II code. Permanent National codes will be used

by Medicaid rather than the temporary codes. ***Please note that not all 2006 codes may be covered automatically by Medicaid.**

For non-covered services (NC), refer to the RBRVS file, or the applicable manual, etc., DME, J-Q code listing will be posted on the Bureau's web page at www.wvdhhr.org/bms. This notification will also appear on the Bureau's web page, as well as the banner pages of remittance vouchers.

620 THIRD PARTY LIABILITY (TPL)

Medicaid is often referred to as the "payer of last resort." TPL is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid enrolled providers must always seek primary reimbursement from other liable resources, including private or public insurance entities.

Federal regulations require that State Medicaid Administration identify any third-party resource available to meet the medical expenses of a member. The "third party" may be an individual, institution, corporation, or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, United Mine Worker of America (UMWA) benefits, Veterans Administration (VA) benefits, Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), Medicare, etc. No Medicaid reimbursement will be made if the service is the responsibility of a public or private Workers Compensation Plan.

All providers must ask Medicaid members if he or she has other public or private insurance or if there is potential that another entity may be liable for the service expense. Once identified, the provider must bill the third party. After receipt of payment or notice of denial for services rendered, the provider may then bill the claim to Medicaid with an attached copy of the Explanation of Benefits (EOB) from the primary payer. Medicaid will then reimburse the lesser amount of the remainder of an approved claim up to the Medicaid allowable amount or the co-insurance and/or deductible amount.

Medicaid covered services which currently require a prior authorization (PA) from the BMS Utilization Management Contractor (UMC) will no longer need a UMC PA if a primary insurance approves that service. An approved service has one of the following listed on the explanation of benefits (EOB): allowed amount, deductible amount, co-insurance amount or payment amount. The EOB must accompany the invoice. If the service is not allowed by the primary insurance, but is a covered service for Medicaid and the service requires a PA from the UMC, Medicaid policy will be enforced.

Orthodontic and periodontic services will still require a Medicaid prior authorization from the UMC, when applicable, regardless of primary insurance requirements.

If the member receives the insurance payment or notice of denial, it is the responsibility of the member to forward the payment or denial to the provider. The member is considered "private pay" until such time as the member supplies needed information.

Medicaid members are not responsible for any third party related co-insurance amounts, deductible amounts, or Health Maintenance Organization (HMO) related co-pays and deductibles, even if the claim payment is zero ($0.00) when the claim payment has been

reduced to zero ($0.00) as a result of the insurance payment or capitation agreement. Medicaid will not reimburse for contractual adjustments, e.g., UMWA deductibles/co-payments or deductibles and co-payments related to HMOs and capitation agreements. The member is also not responsible for these charges.

When a third party has paid as primary and Medicaid is paying as secondary, the system will calculate the Medicaid allowed amount and then compare the co-insurance/co-pay amount and the deductible amount to the difference between the paid amount and the Medicaid allowed amount and pay the lesser of these amounts.

Example 1:

Medicaid allowed amount	$100.00
Insurance paid amount	$ 50.00
Co-insurance/co-pay amount due	$20.00
Difference	$ 50.00
Deductible amount due	$10.00
Total amount due	$30.00

Medicaid would pay $30.00 because that is the lesser amount.

Example 2:

Medicaid allowed amount	$100.00
Insurance paid amount	$ 50.00
Co-insurance/co-pay amount due	$ 0.00
Difference	$ 50.00
Deductible amount due	$ 0.00
Total amount due	$ 0.00

Medicaid would pay $ 0.00 because that is the lesser amount.

Example 3:

Medicaid allowed amount	$100.00
Insurance paid amount	$ 50.00
Co-insurance/co-pay amount due	$0.00
Difference	$ 50.00
Deductible amount due	$100.00
Total amount due	$100.00

Medicaid would pay $50.00 because that is the lesser amount.

Providers must include the co-insurance/co-pay and deductible amounts in their electronic 837 transactions. A copy of the explanation of benefits (EOB) should then be mailed to Unisys with the member Medicaid ID number and provider number listed on the EOB. If a provider is billing on paper, a copy of the explanation of benefits (EOB) must accompany the claim. If a claim is denied by the insurance, the EOB must include the denial reason(s) not just the denial code.

Some West Virginia Medicaid members who are age 65 years or older, or disabled, or have End Stage Renal Disease, or other qualifying Medicare diagnoses, are also eligible for Medicare benefits. Medicare is therefore the primary payer for services covered by both Medicare and Medicaid. In such instances, West Virginia Medicaid pays the Medicare deductible and coinsurance amounts, up to WV Medicaid fee schedule.

All TPL related claims that are not Medicare are subject to the timely filing requirements of 12 months from date of service. Claims that are Medicare and Third Party Liability (TPL) related are subject to a filing deadline of 12 months from the date of the Medicare payment. If another third party is billed for a service and the 1 year filing deadline for Medicaid billing is almost exhausted, the provider should bill Medicaid immediately even though the other third party has not furnished the provider with information about payment. The claim should be billed on paper. A note explaining the situation and a copy of relevant documentation must be attached to the claim when submitted to Medicaid. Even if Medicaid denies the claim, the submission will give the provider another year (from the 1-year anniversary of the date of service) to file a claim with Medicaid while the primary payer processes the claim.

In accordance with Federal regulations, a provider may not refuse to furnish services covered under a third party plan to an individual who is also eligible for Medicaid. A provider may not elect to bill Medicaid primary knowing the existence of potential TPL.

For additional TPL information and requirements please refer to Chapter 100, General Information, Chapter 300, Provider Participation Requirements, Chapter 400, Member Eligibility, and Chapter 800, General Administration.

620.1 COORDINATION OF BENEFITS (COB)

Medicaid members may have other third-party coverage of health expenses, such as Medicare, employment-related coverage, Medicare supplemental or private health insurance, long-term care insurance, automobile insurance, court judgments, or Workers' Compensation. For members with multiple plan coverage, coordination of benefits is the process that involves determining the order in which insurers are billed for a given service.

As required by law, Medicaid is the "payer of last resort," meaning that other parties must be billed before Medicaid can be billed for the service. In other words, the other party is the primary payer and Medicaid is the secondary or perhaps tertiary payer. All resources must be exhausted before Medicaid can consider payment. In addition, no Medicaid payment is made for services associated with a medical condition covered by Workers' Compensation. When the Ryan White Fund is available to a Medicaid member, the Ryan White Fund is the payer of last resort. Catastrophic Illness and Breast and Cervical Cancer Programs are also the payer of last resort.

West Virginia Medicaid cannot be billed for services that a member receives but the provider makes available at no charge to other individuals or groups of individuals.

620.2 TORT RECOVERY - OTHER INSURANCE SETTLEMENTS

In the case of TPL, the provider is required to pursue the possibility of TPL if the services provided are a result of an accident or trauma. If, after a reasonable time, a settlement has not been reached or payment from the liable party has not been received, the provider may choose to bill West Virginia Medicaid. However, you must accept the Medicaid payment as payment in full and cannot refund the West Virginia Medicaid Program in order to pursue reimbursement from any settlement proceeds.

The provider should secure information regarding possible third-party coverage and should require an assignment of benefits prior to the release of any information that can be used for insurance settlement.

Under section 1912(b) of the Social Security Act, the member is entitled to any remaining recovery amount after the Medicaid Program (both Federal and State shares) has been reimbursed.

When billing West Virginia Medicaid, documentation of all recovery efforts including the name, address and phone number of any attorney or insurance company must be submitted. The Bureau for Medical Services will then be responsible for recovering the amount of Medicaid payment from the liable third party.

All TPL related claims that are not Medicare are subject to the timely filing requirements of 12 months from date of service. Claims that are Medicare and TPL related are subject to a filing deadline of 12 months from the date of the Medicare payment.

620.3 RELATIONSHIP TO MEDICARE (DUAL ELIGIBLE)

Medicaid covers medically necessary health services furnished to individuals who meet specific income, resource and eligibility standards. Medicare is a Federal program that offers health insurance coverage to individuals 65 years of age or older, to those who have received Social Security disability benefits for 24 consecutive months, to those who have end stage renal disease, to those on advanced life support, and to other eligible individuals, as specified by other provisions of the Social Security Act.

West Virginia Medicaid covers the applicable co-insurance and deductible amounts, not to exceed Medicaid's allowable payment, for services covered by Medicare Parts A and B for all eligible Medicaid members who are also entitled to Medicare benefits. The Medicaid Program may also provide payment for services not covered by Medicare.

A member with both Medicare and Medicaid coverage is identified as "dual eligible." Medicaid reimburses secondary to Medicare. If a Medicare Supplemental policy exists in addition to Medicare and Medicaid coverage, Medicaid is the third party payer subsequent to Medicare and Medicare Supplemental payments.

Refer to Chapter 300 for other specific provider information on the Medicare Program and its relationship to the West Virginia Medicaid Program, including Medicare provider numbers as part of your Medicaid enrollment responsibilities.

630 MMIS REIMBURSEMENT OR PAYMENT FUNCTIONS

The Medicaid Management Information System (MMIS) provider payment subsystem contains a gross adjustment and payment recovery function. These functions are routinely employed as follows:

630.1 GROSS ADJUSTMENTS

The gross adjustment function is used to make a lump sum provider payment. This function is used to pay: claims corrections, cost report settlements (amounts due provider), disproportionate share hospital payments, HMO payments, and Medicare Part A and B premium payments. All gross adjustments must be reviewed and approved by BMS staff as an internal control measure.

630.2 PAYMENT RECOVERIES

The payment recovery function is used to recover provider overpayments. Recoveries generally occur when providers bill incorrect services with higher rates, audit findings indicate inappropriate billings, and cost report settlements (amounts due Medicaid). Various authorized BMS staff prepares recoveries. The unit supervisor authorizes claim overpayment recoveries. The Department's Office of Accountability and Management Reporting authorize cost report settlement recoveries. The Bureau's Chief Financial Officer, Legal Counsel, Surveillance and Utilization Review Unit Director, or Commissioner authorizes audit-finding recoveries.

Refer to Chapter 800 for information on Administrative Hearings providing a process for providers to contest allegedly erroneous payment recoveries.

640 SPECIFIC PROGRAM REIMBURSEMENT

Specific programs are identified below in alphabetical order:

640.1 AGED AND DISABLED WAIVER SERVICES

Services are reimbursed based on the Medicaid fee schedule.

640.2 BEHAVIORAL HEALTH CLINIC SERVICES

Services are reimbursed based on the Medicaid fee schedule.

640.3 BEHAVIORAL HEALTH REHABILITATION SERVICES

Services are reimbursed based on the Medicaid fee schedule.

640.4 DENTAL SERVICES

West Virginia’s RBRVS fee schedule is used to pay for dental surgeries covered by the schedule when billed by a physician. Other covered dental services are paid using a fee schedule that establishes a fee for each American Dental Association (ADA) procedure code. In each case, Medicaid payment is based on the lower of the amount of the dentist charges for the service or the fee schedule amount.

640.5 DURABLE MEDICAL EQUIPMENT

Medicare fee schedules are used to pay for Durable Medical Equipment (DME), medical supplies and orthotic and prosthetic devices. DME and prosthetic or orthotic devices are separated into the following classes:

- Inexpensive or other routinely purchased DME
- Items requiring frequent and substantial servicing
- Customized items
- Prosthetic and orthotic devices
- Capped rental items
- Oxygen and oxygen equipment.

A separate method applies to each class. Medicaid payment is made on a rental or purchase basis. The total payment for rented equipment may not exceed the cost of purchasing the equipment. Custom items are constructed for the use of an individual and may not be used by anyone else, and may be purchased for that individual. All other items of medical equipment are reimbursed on a 10-month capped rental basis.

Medicaid payment is based on the lower of the amount the supplier charges for an item or the fee schedule amount. This same rule applies to payments for repairs and maintenance.

640.6 FREE STANDING AMBULATORY SURGICAL CENTERS

Reimbursement for these services is 90 percent of the Ambulatory Surgical Center levels of reimbursement determined by Medicare.

640.7 HOME HEALTH CARE SERVICES

Medicare fee schedules are used to determine the amount paid for skilled home health care for the following services: nursing care, rehabilitation services (occupational therapy, physical therapy, and speech pathology), home health aide services, and medical social services. The unit of payment is a visit.

Medicare fee schedules are also used to determine the amount paid to home health agencies for DME, medical supplies, and orthotic and prosthetic devices.

Medicaid payment is based on the lower of the amount a home health agency charges for a service or item or the fee schedule amount.

640.8 HOSPICE SERVICES

Hospital hospice and home hospice reimbursements are based on the Medicaid fee schedule. Nursing home hospice is reimbursed a percentage of the patient specific nursing home rate.

640.9 HOSPITAL INPATIENT CARE SERVICES

West Virginia Medicaid pays a prospective rate for each inpatient discharged from an acute care hospital. The rate is fixed and is established before care is provided. The rate depends on the DRG to which a patient is assigned. Patients are classified into DRGs based on their diagnoses, surgical procedures, age, and other relevant criteria. The payment rate varies directly with a patient's medical needs and expected treatment costs, and is adjusted for hospital wage

differences and medical education costs, if applicable. Cost differences between large urban hospitals and all other hospitals are also recognized.

Additional amounts are paid for patients who are extraordinarily costly to treat ("high cost outlier cases") and to disproportionate share hospitals. Payment for capital costs is on a prospective, per inpatient basis. Payment for direct medical education costs is reimbursed in a lump-sum amount.

Special prospective payment rules apply to community hospitals. Psychiatric, rehabilitation, and rural primary care hospitals are reimbursed on a cost-related basis**.**

Payment to out-of-State hospitals is based on the in-State prospective payment system.

640.10 HOSPITAL OUTPATIENT CARE SERVICES

Hospital outpatient services are reimbursed using several different methodologies. The following are examples of these methodologies:

- Emergency Room and Observation are reimbursed using the Medicaid fee schedule.
- Surgeries are reimbursed at a set amount multiplied by the total unit of time. Recovery is also based on a set amount multiplied by the total units of time.
- Radiology, physical therapy, and occupational therapy services are reimbursed using RBRVS.
- Critical Access Hospital (CAH) services are reimbursed by billing outpatient services at an encounter rate set by the Office of Audits or by fee for service, and are allowed to choose the method of reimbursement.

640.11 LABORATORY SERVICES

Medicare fee schedules are used to pay for clinical diagnostic laboratory tests provided by all clinical laboratories, except hospital-based laboratories performing such tests for their own inpatients. Payment for laboratory services is based on the lower of 90 percent of the Medicare fee or the amount the provider charges for the service.

Certain tests exempt from Medicare's fee schedule for clinical diagnostic laboratory services are paid under the RBRVS fee schedule. Specific Federal rules apply for determining payments for laboratory profile tests and organ/disease panels.

640.12 MR/DD SERVICES

The MR/DD program reimburses for services using the Medicaid fee schedule.

640.13 NURSING FACILITY CARE SERVICES

Reimbursement for nursing facilities is a cost-based per diem based on facility operational costs, nursing services, and investment/cost of capital and patient acuity.

640.14 PERSONAL CARE SERVICES

Personal Care Services are reimbursed using the Medicaid fee schedule.

640.15 PHARMACY SERVICES

Maximum reimbursement for each drug claim processed will be based on the lowest of:

(1) The usual and customary charge to the general public;

(2) The Maximum Allowable Cost (MAC) for each multiple-source drug as defined in 42 CFR 447.332 and published in the Federal Register plus a dispensing fee. A listing of Federal Multiple Source Drug Limits is available on the Centers for Medicare and Medicaid Services (CMS) website, www.CMS.gov/medicaid/drug10.htm.

EXCEPTION: The MAC shall not apply in any case where a physician certifies in his/her own handwriting that, in his/her medical judgment, a specific brand is medically necessary for a particular patient. A notation like "brand medically necessary" written by the physician on the prescription above his/her signature is an acceptable certification. A procedure for checking a box on a form will not constitute an acceptable certification. All such certified prescriptions must be maintained in the pharmacy files and are subject to audit by BMS.

(3) The State Maximum Allowable Cost (SMAC) plus a dispensing fee;

(4) The Medicaid AWP (MAWP) established by the Federal Office of the Inspector General plus a dispensing fee;

(5) Estimated Acquisition Cost (EAC) plus a dispensing fee. The EAC is defined as Average Wholesale Price (AWP) minus 12%.

640.16 PHYSICIAN SERVICES

Medicare's RBRVS is used to determine the fees that physicians are paid to diagnose and treat Medicaid members. The RBRVS is also used to pay for certain services furnished by other practitioners. The list of such practitioners includes:

- Audiologists
- Advanced registered nurse practitioners
- Certified registered nurse anesthetists
- Chiropractors
- Occupational therapists
- Optometrists
- Physical therapists
- Podiatrists

The payment amount is based on the lower of the fee or the amount the practitioner charges for the service.

The RBRVS is a list of services with a weight or relative value unit (RVU) assigned to each service. The weight indicates a service's costliness compared to that of the average service, which has a weight of 1.0 unit. A service with a weight of 1.75 units is therefore 175 percent as costly as the average service, while a service with a weight of 0.73 units is 73 percent as costly as the average service. The more a service costs to provide, the higher the amount paid for the service.

The fee for a service is determined by multiplying the service's weight by a conversion factor. The conversion factor is the dollar value of 1.0 relative value unit. The Bureau for Medical Services establishes the conversion factor for services provided to Medicaid patients. If the conversion factor was $30.00 and the weight for a service was 2.25, the fee for that service would be $67.50.

Conversion Factor x Relative Value Units = Reimbursement

$30.00 x 2.25 = $67.50

The RBRVS file can be found on the Bureau for Medical Services website. The information on the file shows the weights assigned to services covered by the RBRVS fee schedules. The Federal Government updates the weights annually.

A service's total weight consists of the following parts:

- Physician Work—time, effort, and skill that a physician (or other practitioner) expends on average to provide the service.
- Practice Expenses—wages, salaries, and fringe benefits paid to office staff, rent, utilities, and other office expenses plus medical equipment.
- Malpractice Insurance—cost of professional liability insurance.

There are two different practice expenses for many services. That explains why there are two total weights for most services. The weight that applies to a particular service depends on where the service is provided.

- The "facility practice expense" weight applies if the service was provided in a hospital or other facility setting
- The "non-facility practice expense" weight applies if the service was provided in a practitioner office setting.

The "facility practice expense" weight, if applicable, is often lower than the "non-facility practice expense" weight. The reason is so because the facility absorbs part of the cost of providing the service when the service is provided in a facility setting. The physician is not paid for costs absorbed by the facility.

Services that cannot be performed in a non-facility setting do not have a non-facility practice weight and no total weight is shown for these services. Such services are often surgical procedures that require the physician to have access to equipment and personnel that are not available in outpatient settings.

Anesthesiology—Medicaid fees for anesthesiology services are calculated somewhat differently from the fees paid for all other physician services. The fee equals the conversion factor for anesthesia services multiplied by the sum of the base units and time units for a service and not relative value units. The base units for a given anesthesia service are the same every time that service is provided and established by the American Society of Anesthesiologists (ASA). The time units depend on the length of time to provide the service. Time units are expressed in 15-minute blocks and are expressed in whole units of time. Thus, a service that takes 75 minutes would be assigned 5 time units.

If an anesthesia service has 3 base units and 5 time units and the anesthesia conversion factor is $15.25 per unit, the fee would be $122.00. An example follows:

Conversion Factor x Total Units = Reimbursement

$15.25 x 8 = $122.00

Time units do not apply to certain anesthesia services. These services are paid using base units only.

640.17 PSYCHOLOGY SERVICES

Most of the services for psychologists are reimbursed using RBRVS. Currently there is one procedure code that is reimbursed at 90 percent of Medicare's fee schedule.

640.18 RADIOLOGY AND CERTAIN OTHER DIAGNOSTIC SERVICES

Radiology services have a professional and technical component. The professional component (identified by modifier 26) represents the portion of the service associated with the physician's interpretation of the test. The technical component (identified by modifier TC) represents the portion of the service associated with the performance of the test. The physician may be paid for the professional component while a hospital where the service is furnished may be paid for the technical component. Alternately, the physician is paid for both components if he or she performs the entire or global service—that is, performs and interprets the service.

For example, the total weight for CPT 70010 (Contrast X-ray of Brain) is 5.28. This consists of a total weight of 5.28 units, consisting of weight for 1.56 units for the professional component and 3.71 units for the technical component.

640.19 RHC/FQHC

Medicare sets reimbursement for these services.

640.20 TRANSPORTATION

Reimbursement for transportation services utilizes the Medicaid fee schedule. Separate rates are paid for ground and air ambulances, including an amount for mileage.

640.21 VISION SERVICES

Vision services are reimbursed using the Medicaid fee schedule. Additionally, some services are paid at 90 percent of the Medicare fee.