12VAC30-80-190. State agency fee schedule for RBRVS.

A. Reimbursement of fee-for-service providers. Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for-service providers, with the exception of home health services (see 12VAC30-80-180) and durable medical equipment services (see 12VAC30-80-30), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS).

B. Fee schedule.

1. For those services or procedures which are included in the RBRVS published by the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.

2. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by CMS. DMAS shall adjust CMS' CFs by additional factors so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. ~~DMAS shall calculate a separate additional factor for obstetrical/gynecological procedures (defined as maternity care and delivery procedures, female genital system procedures, obstetrical/gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT)~~

~~manual)~~ DMAS may revise the additional factors when CMS updates its RVUs or CFs so that no change in expenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by CMS. The calculation of the additional factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule. The determination of the additional factors required above shall be accomplished by means of the following calculation:

a. The estimated amount of DMAS expenditures if DMAS were to use Medicare's RVUs and CFs without modification, is equal to the sum, across all relevant procedure codes, of the RVU value published by the CMS, multiplied by the applicable conversion factor published by the CMS, multiplied by the number of occurrences of the procedure code in DMAS patient claims in the most recent period of time (at least six months).

b. The estimated amount of DMAS expenditures, if DMAS were not to calculate new fees based on the new CMS RVUs and CFs, is equal to the sum, across all relevant procedure codes, of the existing DMAS fee multiplied by the number of occurrences of the procedures code in DMAS patient claims in the period of time used in (B)(2)(a) above.

c. The relevant additional factor is equal to the ratio of the expenditure estimate (based on DMAS fees (B)(2)(b) above) to the expenditure estimate based on unmodified CMS values in (B)(2)(a) above.

d. DMAS shall calculate a separate additional factor for:

(i) Emergency Room Services (defined as the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) codes 99281, 99282, 99283, 99284, and 99285);

(ii) Obstetrical/Gynecological Services (defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual);

(iii) Pediatric Services (defined as Evaluation and Management (E&M) procedures, excluding those listed in (B)(2)(d)(i) above, as defined by the AMA's annual publication of the CPT manual for recipients under age 21);

(iv) Adult Primary and Preventive Services (defined as E&M procedures, excluding those listed in (B)(2)(d)(i) above, as defined by the AMA's annual publication of the CPT manual for recipients age 21 and over); and,

(v) All other procedures set through the RBRVS process combined.

3. For those services or procedures for which there are no established RVUs, DMAS shall approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service methodology.

4. Fees shall not vary by geographic locality.

5. Effective for dates of service on or after May 1, 2006, fees for Emergency Room Services (defined in B(2)(d)(i) of this section) shall be increased by 3 percent relative to the fees in effect on July 1, 2005.

C. Effective for dates of service on or after ~~September~~ May 1, ~~2004~~ 2006, fees for ~~obstetrical/gynecological procedures~~ Obstetrical/Gynecological Services (defined ~~as maternity care and delivery procedures, female genital system procedures, obstetrical/gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual~~ in (B)(2)(d)(ii) above) shall be increased by ~~34%~~ 2.5% relative to the fees in effect on July 1, ~~2004~~ 2005. ~~This 34% increase shall be a one-time increase, but shall be included in subsequent calculations of the relevant additional factor described in subdivision 2 of this subsection.~~

D. Effective for dates of service on or after May 1, 2006, fees for Pediatric Services (defined in (B)(2)(d)(iii) above) shall be increased by 5 % relative to the fees in effect on July 1, 2005.

E. Effective for dates of service on or after May 1, 2006, fees for Adult Primary and Preventive Services (defined in (B)(2)(d)(iv) above) shall be increased by 5 % relative to the fees in effect on July 1, 2005.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services