Attachment 4. 19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

2.a. Outpatient Service - Shall be paid in accordance with Medicare principles of cost reimbursement as set out in the Medicare provider reimbursement manual in effect on October 1, 1982, except that the lower of cost or charges determination will be made separately and without consideration of inpatient cost or charges.

b. Independent Laboratory & X-Ray - Payment not to exceed usual and customary charges or the 75th percentile under Part B of Title XVIII, whichever is less.

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STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

2.a.1. Outpatient Hospital Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

Outpatient hospital services providers will be reimbursed using the cost-to-charge ratio in place as of December 31, 1993. In the event there are new providers since December 31, 1993, reimbursement for them will be established using their most recent cost report submitted to the Office of the Comptroller.

D1110060

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS FOR MEDICAID MANAGED CARE ENROLLEES.

2.a.2. Outpatient Hospital Services

Covered medically necessary emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(D) of the Social Security Act, shall be reimbursed at 74 percent of the 2006 Medicare rates for those services. This methodology does not apply to Medicare crossover claims, which are paid in accordance with Attachment 4.19B, Section 24.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

2.a.3. Outpatient Hospital Services.

1. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for other provider-preventable conditions (PPCs).

2. No reduction in payment for Other Provider-Preventable Conditions (OPPCs) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

3. Reductions in provider payment may be limited to the extent that the following apply:

   a. The identified provider-preventable conditions would otherwise result in an increase in payment.

   b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions in the following manner:

      Outpatient hospital services providers are paid based on a fee-for-service payment methodology. It is the responsibility of the outpatient hospital services provider to identify and report any OPPC and not seek payment from Medicaid for services provided to treat an OPPC.

   c. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

4. Outpatient hospital records will be retroactively reviewed by the State or its agent. If any services are identified that are due to a PPC, then the State or its agent will initiate recoupment for the identified overpayment.

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STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

2.a.3. Outpatient Hospital Services, continued.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Sections 4.19A and 4.19B.

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

On and after the effective date below, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NEs) as defined by the National Coverage Determination (NCD). The Never Events (NEs) as defined in the NCD include Inpatient Hospitals, Outpatient Hospitals, Clinics, Ambulatory Surgical Centers (ASCs), and practitioners, and these providers will be required to report NEs.

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STATE: TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES – OTHER TYPES OF CARE

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (RHC).

Payment for covered services provided by RHCs shall be in accordance with the methods of payment below:

___X___ The payment methodology for RHCs will conform to section 702 of the Benefit Improvement and Protection Act (BIPA) 2000 legislation.

___X___ The payment methodology for RHCs will conform to the BIPA 2000 requirements Prospective Payment System.

___X___ The payment methodology for RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1) is agreed to by the State and the center or clinic; and
2) results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

The State is using the cost reports filed with Medicare for FY 1999 and FY 2000. For the period January 1, 2001 to September 30, 2001, RHCs will be paid their average 1999 and 2000 costs, adjusted for any change in scope of services. The RHCs have a variety of fiscal year ends. The clinics already have Medicare cost reports so, as a practical matter, the State will use those reports. With respect to the fiscal year ends, for the 1999 year, the State will use the clinic year end that has the most months in calendar year 1999 and the 2000 year end with the most months in calendar year 2000. For a clinic with a March 31 fiscal year end, the State will use their FYE March 31, 2000 cost report for 1999 (because most of the months fall in 1999), and the State will use their FYE March 31, 2001 cost report for 2000. These are the two years used to compute the average cost for the first part of BIPA and also for computing the prospective rate for the second part.

The State is using the average cost per visit for 1999 and 2000 to compute the prospective payment system (PPS) rate. Total costs are divided by total visits for each year and then averaged to determine the rate. The PPS rate, effective October 1, 2001 will be indexed for a nine-month period to July 1, 2002 which will place the rates on the state's fiscal year. From that point on, the Medicare Economic Index (MEI) will be applied annually so that the PPS remains on the state's fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

The cost reports submitted by the clinics are being desk reviewed, and the cost centers (and visits) excluded by Medicare, but covered by Medicaid, are being restored along with the applicable overhead costs. Also, cost centers not covered by Medicaid are excluded.

The RHCs have to undergo a formal Medicare application and approval process for a change in their scope of services. The State intends to use this process for this purpose.

The State has worksheets in place which will compute the changes in scope of services. Clinics first inform the State that they have a change and provide the actual costs, visits, and (if applicable) square footage allocated to the new services. The change in cost will then be factored into an adjusted PPS rate.

The State is requiring the clinics to submit cost reports on a continuing basis even though costs will not factor into the PPS in subsequent years. Having the cost reports will aid the State auditing effort and will alert the State to any reductions in scope of services that may not have been reported. The clinics need only incur a small postage charge to meet this requirement, the State is only asking for a copy of their as filed Medicare report.

For clinics that began operations during the 1999 and 2000 period, the State is using the past year cost report filed with Medicare. The State believes that even though one period is a short year, it will not impact the average cost per visit.

For new clinics that qualify after 2000, the State will use the average PPS rate for neighboring clinics with similar caseloads. If there are no such similar clinics, the State will use the average PPS rate for all clinics on an interim basis until the clinic can provide some projected costs upon which the State can base the clinic's projected PPS rate. After the clinic submits its cost report, the State will compare projected costs and visits with the actual data, and the State will adjust the PPS rate as necessary.

Within 60 days after the end of each quarter, the RHCs will report to the State actual TennCare visits and the corresponding managed care organization (MCO) payments received. The State will then make quarterly payments to the clinics for the actual difference between the amount of MCO reimbursements received and the BIPA required PPS amount. In the event that a clinic does not provide the necessary visits and MCO payments timely, the State will make an estimated quarterly payment and reconcile the difference once the actual data for the quarter are received.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES – OTHER TYPES OF CARE

Alternative payment methodology:

The RHCs have a variety of fiscal year ends. The State is using the two most recent Medicare cost reports on file as of September 30, 2005, to determine an average cost per visit to determine the prospective payment system (PPS) rate. As examples, for a center with a March 31 fiscal year end, the State will use its FYE March 31, 2005 and FYE March 31, 2004 cost reports; for a center with a September 30 fiscal year end, the State will use its FYE September 30, 2004, and September 30, 2003 cost reports.

Total costs are divided by total visits for each of the two cost report periods and then averaged to determine the PPS rate, adjusted for any change in scope of services, to be paid to the RHCs for the period January 1, through September 30, 2006. The facility-specific PPS rates will be indexed, using the Medicare Economic Index (MEI) for a nine-month period effective for dates of service on and after October 1, 2006. The rates will again be indexed for a nine-month period to be effective for dates of service on and after July 1, 2007. Thereafter, the (MEI) will be applied annually so that the PPS coincides with the State's fiscal year end of June 30.

The cost reports submitted by the clinics are being desk reviewed, and the cost centers (and visits) excluded by Medicare, but covered by Medicaid, are being restored along with the applicable overhead costs. Also, cost centers not covered by Medicaid are excluded.

The RHCs have to undergo a formal Medicare application and approval process for a change in their scope of services. The State intends to use this process for this purpose.

The State has worksheets in place which will compute the changes in scope of services. Clinics would first inform the State that they have had a change in their scope of services and then would provide the actual costs, visits, and square footage statistics, as applicable, allocated to the new services. The change in costs will be factored into an adjusted PPS rate.

The State is requiring the clinics to submit copies of the as-filed Medicare cost reports annually, though costs will not factor into the PPS in subsequent years. The cost reports will aid the auditing effort by alerting the State to any reductions in scope of services that may not have been reported. The clinics need only incur a nominal fee to meet this requirement.

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RATES – OTHER TYPES OF CARE

For existing clinics that qualify after March 31, 2005, the State is using the most recent cost report filed with Medicare to determine its average cost per visit and PPS rate. The State believes that although only one period is used, it will not materially impact the average cost per visit.

For new clinics that qualify after March 31, 2005 (thus having no cost report history), the State will use the average PPS rate for neighboring clinics with similar caseloads. If no such clinics exist, the State will use the average PPS rate for all clinics statewide on an interim basis until the clinic can provide pro forma data, which the State will use to establish an interim PPS rate. After the first full year actual cost report is received, the State will compare the pro forma data to the actual cost report data and adjust the PPS rate as necessary.

Within 60 days after the end of each quarter, the RHCs will report to the State the actual TennCare visits and the corresponding managed care organization (MCO) payments received. The State will then make quarterly payments to the clinics for the actual difference between the amount of MCO reimbursements received and the BIPA-required PPS amount.

Regardless of methodology, payment must be at least equal to the BIPA PPS rate. The State will compare the alternative rate against the PPS rate on a yearly basis. If the PPS rate is more, then the State will reimburse the facility the difference. If the PPS is less, then no recoupment will be made.

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STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

2.b.1. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

Reimbursement for covered services shall consist of a single rate per visit as determined by the Medicare carrier pursuant to 42 CFR 405.2464 through 405.2470.

D1050061

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES – OTHER TYPES OF CARE

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Payment for covered services provided by FQHCs shall be in accordance with the methods of payment below:

__X__ The payment methodology for FQHCs will conform to section 702 of the Benefits Improvement and Protection Act (BIPA) 2000 legislation.

__X__ The payment methodology for FQHCs will conform to the BIPA 2000 requirements Prospective Payment System.

__X__ The payment methodology for FQHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1) is agreed to by the State and the center or clinic; and
2) results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

The State is using the cost reports filed with Medicare for FY 1999 and FY 2000. For the period January 1, 2001 to September 30, 2001, FQHCs will be paid their average 1999 and 2000 costs, adjusted for any change in scope of services. The FQHCs have a variety of fiscal year ends. The centers already have Medicare cost reports so as a practical matter, the State will use those reports. With respect to the fiscal year ends, for the 1999 year, the State will use the center year end that has the most months in calendar year 1999 and the 2000 year end with the most months in calendar year 2000. For a center with a March 31 fiscal year end, the State will use their FYE March 31, 2000 cost report for 1999 (because most of the months fall in 1999), and the State will use their FYE March 31, 2001 cost report for 2000. These are the two years used to compute the average cost for the first part of BIPA and also for computing the prospective rate for the second part.

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The State is using the average cost per visit for 1999 and 2000 to compute the prospective payment system (PPS) rate. Total costs are divided by total visits for each year and then averaged to determine the rate. The PPS rate, effective October 1, 2001 will be indexed for a nine-month period to July 1, 2002 which will place the rates on the state's fiscal year. From that point on, the Medicare Economic Index (MEI) will be applied annually so that the PPS remains on the state's fiscal year.

The cost reports submitted by the clinics are being desk reviewed, and the cost centers (and visits) excluded by Medicare, but covered by Medicaid, are being restored along with the applicable overhead costs. Also, cost centers not covered by Medicaid are excluded.

The FQHCs have to undergo a formal Medicare application and approval process for a change in their scope of services. The State intends to use this process for this purpose.

The State has worksheets in place which will compute the changes in scope of services. Clinics first inform the State that they have a change and provide the actual costs, visits, and (if applicable) square footage allocated to the new services. The change in cost will then be factored into an adjusted PPS rate.

The State is requiring the clinics to submit cost reports on a continuing basis even though costs will not factor into the PPS in subsequent years. Having the cost reports will aid the State auditing effort and will alert the State to any reductions in scope of services that may not have been reported. The clinics need only incur a small postage charge to meet this requirement, the State is only asking for a copy of their as filed Medicare report.

For clinics that began operations during the 1999 and 2000 period, the State is using the past year cost report filed with Medicare. The State believes that even though one period is a short year, it will not impact the average cost per visit.

For new clinics that qualify after 2000, the State will use the average PPS rate for neighboring clinics with similar caseloads. If there are no such similar clinics, the State will use the average PPS rate for all clinics on an interim basis until the clinic can provide some projected costs upon which the State can base the clinic's projected PPS rate. After the clinic submits its cost report, the State will compare projected costs and visits with the actual data, and the State will adjust the PPS rate as necessary.

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Within 60 days after the end of each quarter, the FQHCs will report to the State actual TennCare visits and the corresponding managed care organization (MCO) payments received. The State will then make quarterly payments to the clinics for the actual difference between the amount of MCO reimbursements received and the BIPA required PPS amount. In the event that a clinic does not provide the necessary visits and MCO payments timely, the State will make an estimated quarterly payment and reconcile the difference once the actual data for the quarter are received.

Alternate payment methodology:

The FQHCs have a variety of fiscal year ends. The State is using the two most recent Medicare cost reports on file as of September 30, 2005, to determine an average cost per visit to determine the prospective payment system (PPS) rate. As examples, for a center with a March 31 fiscal year end, the State will use its FYE March 31, 2005 and FYE March 31, 2004 cost reports; for a center with a September 30 fiscal year end, the State will use its FYE September 30, 2004, and September 30, 2003 cost reports.

Total costs are divided by total visits for each of the two cost report periods and then averaged to determine the PPS rate, adjusted for any change in scope of services, to be paid to the FQHCs for the period January 1, through September 30, 2006. The facility-specific PPS rates will be indexed, using the Medicare Economic Index (MEI) for a nine-month period effective for dates of service on and after October 1, 2006. The rates will again be indexed for a nine-month period to be effective for dates of service on and after July 1, 2007. Thereafter, the (MEI) will be applied annually so that the PPS coincides with the State's fiscal year end of June 30.

The cost reports submitted by the clinics are being desk reviewed, and the cost centers (and visits) excluded by Medicare, but covered by Medicaid, are being restored along with the applicable overhead costs. Also, cost centers not covered by Medicaid are excluded.

The FQHCs have to undergo a formal Medicare application and approval process for a change in their scope of services. The State intends to use this process for this purpose.

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The State has worksheets in place which will compute the changes in scope of services. Clinics would first inform the State that they have had a change in their scope of services and then would provide the actual costs, visits, and square footage statistics, as applicable, allocated to the new services. The change in costs will be factored into an adjusted PPS rate.

The State is requiring the clinics to submit copies of the as-filed Medicare cost reports annually, though costs will not factor into the PPS in subsequent years. The cost reports will aid the auditing effort by alerting the State to any reductions in scope of services that may not have been reported. The clinics need only incur a nominal fee to meet this requirement.

For existing clinics that qualify after March 31, 2005, the State is using the most recent cost report filed with Medicare to determine its average cost per visit and PPS rate. The State believes that although only one period is used, it will not materially impact the average cost per visit.

For new clinics that qualify after March 31, 2005 (thus having no cost report history), the State will use the average PPS rate for neighboring clinics with similar caseloads. If no such clinics exist, the State will use the average PPS rate for all clinics statewide on an interim basis until the clinic can provide pro forma data, which the State will use to establish an interim PPS rate. After the first full year actual cost report is received, the State will compare the pro forma data to the actual cost report data and adjust the PPS rate as necessary.

Within 60 days after the end of each quarter, the FQHCs will report to the State the actual TennCare visits and the corresponding managed care organization (MCO) payments received. The State will then make quarterly payments to the clinics for the actual difference between the amount of MCO reimbursements received and the BIPA-required PPS amount.

Regardless of methodology, payment must be at least equal to the BIPA PPS rate. The State will compare the alternative rate against the PPS rate on a yearly basis. If the PPS rate is more, then the State will reimburse the facility the difference. If the PPS is less, then no recoupment will be made.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

2.c.1. Federally Qualified Health Center (FQHC).

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For FQHC services which are covered by Medicare, interim payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For FQHC services which are not covered by Medicare, interim payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

Federally qualified health centers will be cost settled annually in order to assure reimbursement at 95 percent of reasonable allowable cost in FY 2000, 90 percent in FY 2001, 85 percent in FY 2002, and 70 percent in FY 2003 as determined from annual cost reports.

D1010061

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

3. Other Laboratory and X-Ray Services

(1) Independent Laboratory

Clinical diagnostic laboratory services shall be reimbursed at the lesser of:

(a) billed charges, or
(b) the Medicare fee schedule for clinical diagnostic laboratory services, not to exceed the national limitation established by the Consolidated Omnibus Budget Reconciliation Act of 1985.

Laboratory procedures not covered by the Medicare clinical diagnostic laboratory fee schedule shall be reimbursed at the lesser of:

(a) 100% of billed charges,or
(b) 85% of the usual and customary charges at the 50th percentile, or
(c) 85% of the statewide area prevailing charges at the 75th percentile, or
(d) 100% of the statewide maximum fee schedule, where usual and customary charges and area prevailing charges do not exist.

When usual and customary charges, area prevailing charges and the statewide maximum fee schedule do not exist, reimbursement is:

(a) 65% of billed charges.

Payment for any of the above will not exceed the amount that would have been paid on June 30, 1988.

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(2) X-Ray

Reimbursement is not to exceed the lesser of:

(a) 100% of billed charges, or
(b) 85% of the usual and customary charges at the 50th percentile, or
(c) 85% of the statewide area prevailing charges at the 75th percentile, or
(d) 100% of the statewide maximum fee schedule, where usual and customary charges and area prevailing charges do not exist.

When usual and customary charges, area prevailing charges and the statewide maximum fee schedule do not exist, reimbursement is:

(a) 65% of billed charges.

Payment for any of the above will not exceed the amount that would have been paid on June 30, 1988.

D3038293

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

3.a. Other Laboratory and X-ray Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For procedures which are covered by Medicare, laboratory and x-ray service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For procedures which are not covered by Medicare, laboratory and x-ray service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1010060

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

4.b. Early and Periodic Screening, Diagnosis and Treatment

Maximum fees for the following are payable to screening providers.

Age	Screening	Physician Examination and Diagnosis
0 - 2 years	$12.00	$5.00
3 - 11 years	$14.00	$5.00
12 - 20 years	$18.00	$5.00

These fees are based on the cost of providing these services by EPSD&T screening providers. Payment for treatment services is made in accordance with allowable amount of payment to various providers which furnish such services. Reimbursement for screening does not include required immunizations. Reimbursement for the required immunizations will be the average wholesale price of the vaccine plus a $2.00 administration fee. Reimbursement for laboratory services provided under the EPSD&T program will be up to 90% of the current prevailing profile for Independent Laboratories and Private Physicians. Reimbursement of $11.00 is allowed for providing a developmental assessment.

Allowed EPSDT services that are not otherwise covered in the Plan will be reimbursed as follows:

a. Where available, Medicare rates will be utilized.

b. Where Medicare rates are not available, payment will be made in accordance with usual and customary fees. Usual and customary fees will be established using existing methods and practices for establishing such fees. Aggregate payments will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

GW/D4030354

TN No. ~~90-7A~~ DATE/RECEIPT 6/26/91
SUPERSEDES DATE/APPROVED 9/23/91
TN No. 82-22 DATE/EFFECTIVE 4/1/90

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

4.b.1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For EPSD&T services which are covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For EPSD&T services which are not covered by Medicare, EPSD&T services payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1020060

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STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

4.c. Family Planning Services and Supplies - The rates reimbursed family planning clinics are based on the clinic cost per unit of service as determined by the Tennessee Department of Health and Environment's Bureau of Health Services Administration, Division of Family Planning Services in conjunction with the Bureau of Medicaid Administration.

Payments to other providers of family planning services are made in accordance with the methods of payment established for respective providers.

Payments will not exceed the upper limits pursuant to 42 CFR 447.321.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

4.c.1. Family Planning Services and Supplies.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For family planning services and supplies which are covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For family planning services and supplies which are not covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1030060

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

5. Physician services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

Physician service payment is not to exceed the lesser of:

(1) the billed amount,
(2) 85% of the usual and customary charges accumulated by each individual physician, or
(3) 85% of the 75th percentile of the range of weighted customary charges by physicians in the state (Physicians profile) for the 1984 calendar year.

Physician service reimbursement shall not exceed the amount in effect June 30, 1988.

~~5(a) Payment for Pediatric Services~~

1. Office Medical Services -- 91-14 reduced

NEW PATIENT

90000	Office medical service, new patient; brief service	$ 23.00
90010	limited service	$ 30.00
90015	intermediate service	$ 40.00
90017	extended service	$ 50.00
90020	comprehensive service	$ 60.00

ESTABLISHED PATIENT

90030	Office medical service, established patient; minimal service	$ 9.00
90040	brief service	$ 18.00
90050	limited service	$ 22.00
90060	intermediate service	$ 27.00
90070	extended service	$ 32.00
90080	comprehensive service	$ 37.00

2. Emergency Department Services

NEW PATIENT

90500	Emergency department service, new patient; minimal service	$ 25.00
90505	brief service	$ 45.00
90510	~~limited service~~	~~$ 32.50~~

TN No. 90-16 DATE/RECEIPT 6-29-90
SUPERSEDES TN No. 88-11 DATE/EFFECTIVE 4-1-90

Medicaid Physician Participation
Pediatric Services

	Physicians Providing Pediatric Services to the General Population	Physicians Participating in Medicaid	Percentage of Medicaid Participation
First Tennessee Region	144	128	89%
East Tennessee Region	131	105	80%
Southeast Region	50	44	88%
Upper Cumberland Region	55	44	80%
Northwest Region	48	41	85%
Southwest Region	90	55	61%
Mid-Cumberland Region	138	98	71%
South Central Region	61	50	82%
Memphis Shelby County	243	122	50%
Metropolitan/Davidson County	183	141	77%
Knox County	167	108	65%
Hamilton County	86	59	69%
Total	1396	995	71%

GW/D3032125

Medicaid Physician Participation
Obstetrical Services

	Physicians Providing Obstetrical Services to the General Population	Physicians Participating in Medicaid	Percentage of Medicaid Participation
First Tennessee Region	58	55	95%
East Tennessee Region	46	40	87%
Southeast Region	13	12	92%
Upper Cumberland Region	30	23	77%
Mid-Cumberland Region	53	51	96%
South Central Region	30	28	93%
Northwest Region	17	16	94%
Southwest Region	26	23	88%
Memphis Shelby County	124	86	69%
Metropolitan/Davidson County	110	75	68%
Knox County	62	56	90%
Hamilton County	43	24	56%
Total	612	489	80%

GW/D3022125

Community Health Agency Regions
State of Tennessee

First Tennessee Region

Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, Washington and Sullivan Counties

East Tennessee Region

Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union Counties

Southeast Region

Bledsoe, Bradley, Franklin, Grundy, Marion, McMinn, Meigs, Polk, Rhea, and Sequatchie Counties

Upper Cumberland Region

Cannon, Clay, Cumberland, Dekalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, Van Buren, Warren, and White Counties

Mid-Cumberland Region

Cheatham, Dickson, Houston, Humphreys, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, and Wilson Counties

South Central Region

Bedford, Coffee, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, and Wayne Counties

Northwest Region

Benton, Carroll, Crockett, Dyer, Gibson, Henry, Lake, Obion, and Weakley Counties

Southwest Region

Chester, Decatur, Fayette, Hardeman, Hardin, Haywood, Henderson, Lauderdale, Madison, McNairy, and Tipton Counties

Memphis/Shelby County

Metropolitan/Davidson County

Knox County

Hamilton County

D3032132

METROPOLITAN STATISTICAL AREAS
Tennessee Counties

1. Chattanooga, Tennessee
   - Hamilton
   - Marion
   - Sequatchie

2. Clarksville, Tennessee
   - Montgomery

3. Johnson City-Kingsport-Bristol, Tennessee
   - Carter
   - Hawkins
   - Sullivan
   - Unicoi
   - Washington

4. Knoxville, Tennessee
   - Anderson
   - Blount
   - Grainger
   - Jefferson
   - Knox
   - Sevier
   - Union

5. Memphis, Tennessee
   - Shelby
   - Tipton

6. Nashville, Tennessee
   - Cheatham
   - Davidson
   - Dickson
   - Robertson
   - Rutherford
   - Sumner
   - Williamson
   - Wilson

7. Jackson, Tennessee
   - Madison

METROPOLITAN STATISTICAL AREAS
Tennessee Counties

8. Non-MSA Counties

Bedford	Fentress	Johnson	Overton
Benton	Franklin	Lake	Perry
Bledsoe	Gibson	Lauderdale	Pickett
Bradley	Giles	Lawrence	Polk
Campbell	Greene	Lewis	Putnam
Cannon	Grundy	Lincoln	Rhea
Carroll	Hamblen	Loudon	Roane
Chester	Hancock	McMinn	Scott
Claiborne	Hardeman	McNairy	Smith
Clay	Hardin	Macon	Stewart
Cocke	Haywood	Marshall	Trousdale
Coffee	Henderson	Maury	Van Buren
Crockett	Henry	Meigs	Warren
Cumberland	Hickman	Monroe	Wayne
Decatur	Houston	Moore	Weakley
DeKalb	Humphreys	Morgan	White
Dyer	Jackson	Obion	
Fayette			

D3142241

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

5(a) Payment for Pediatric Services

1. Office Medical Services --

NEW PATIENT

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
90000	99201	Office medical service, new patient; brief service	$ 23.00
90010	99202	limited service	$ 30.00
90015	99203	intermediate service	$ 40.00
90017	99204	extended service	$ 50.00
90020	99205	comprehensive service	$ 60.00
		ESTABLISHED PATIENT	
90030	---	Office medical service, established patient; minimal service	---
90040	99211	brief service	$ 18.00
90050	99212	limited service	$ 22.00
90060	99213	intermediate service	$ 27.00
90070	99214	extended service	$ 32.00
90080	99215	comprehensive service	$ 37.00

2. Emergency Department Services

NEW PATIENT

90500	---	Emergency department service, new patient; minimal service	---
90505	99281	brief service	$ 45.00
90510	99282	limited service	$ 32.30
90515	99283	intermediate service	$ 59.50
90517	99284	extended service	$ 91.80
90520	99285	comprehensive service	$ 78.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

5(a) Continued.

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
		ESTABLISHED PATIENT	
90530	---	Emergency department service; established patient; minimal service	---
90540	99281	brief service	$ 22.10
90550	99282	limited service	$ 32.30
90560	99283	intermediate service	$ 59.50
90570	99284	extended service	$ 91.80
90580	99285	comprehensive service	$ 78.00
	3.	Immunization Injections *	
90701	90701	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	$ 16.45
90702	90702	diphtheria and tetanus toxoids (DT)	$ 2.00
90704	90704	mumps virus vaccine, live	$ 18.00
90705	90705	measles virus vaccine, live, attenuated	$ 16.15
90706	90706	rubella virus vaccine, live	$ 16.70
90707	90707	measles, mumps, rubella virus vaccine, live	$ 37.00
90708	90708	measles and rubella virus vaccine, live	$ 23.35
90709	90709	rubella and mumps virus vaccine, live	$ 11.00
90712	90712	poliovirus vaccine, live, oral, any	$ 12.60
90737	90737	Hemophilus	$ 20.00

* Medicaid covers only an administration fee when the vaccine is obtained from another source or at no cost.

JUN 14 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

5(a) Continued.

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
		4. Preventive Medicine	
		NEW PATIENT	
90751	99384	Initial history and examination related to the healthy individual, including anticipatory guidance; adolescent (age 12 through 17 years)	NC
90752	99383	late childhood (age 5 through 11 years)	NC
90783	99382	early childhood (age 1 through 4 years)	NC
90754	99381	infant (age under 1 year)	NC
90755	---	Infant care to one year of age, with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and immunization of DPT and oral polio	NC
90757	99432	Newborn care, in other than hospital setting, including physical exam of baby and conference(s) with parent(s)	NC
		ESTABLISHED PATIENT	
90761	99394	Interval history and examination related to the healthy individual, including anticipatory guidance, periodic type of examination; adolescent (age 12 through 17 years)	NC
90762	99393	late childhood (age 5 through 11 years)	NC
90763	99392	early childhood (age 1 through 4 years)	NC
90764	99391	infant (age under 1 year)	NC
90774	99178	Administration & medical interpretation of developmental tests	$ 63.75
90778	94772	Circadian respiratory pattern (pediatric pneumogram) 12 to 24 hour continuous recording, infant	NC

Note: NC = Non-covered. These services are covered through EPSDT.

EPSDT CODES AND COMPARABLE CPT CODES

EPSDT CODES	COMPARABLE CPT CODES
Y0100 - Screening 0-2 years	99381, 99382, 99391, 99392
Y0102 - Screening 3-11 years	99382, 99383, 99392, 99393
Y0103 - Screening 12-20 years	99384, 99385, 99394, 99395
Y0104 - Examination and Diagnosis by a Physician	Any of the above screening codes would be applicable. It is not required that the services be performed by a physician.
Y0105 - Developmental Assessment	99178
Y0106 - Immunization DPT	90701
Y0107 - Immunization MMR	90707
Y0108 - Immunization MR	90708
Y0109 - Immunization Measles	90705
Y0114 - Immunization Rubella	90706
Y0110 - Immunization Mumps	90704
Y0111 - Immunization TOPV	90712
Y0112 - Immunization Td or T	90702, 90703
Y0116 - Lab Hemoglobin	85018
Y0117 - Lab Hematocrit	85014
Y0118 - Lab Sickle Cell	83020
Y0119 - Lab TB Skin Test	86580, 86585
Y0120 - Lab Urinalysis without Microscopic	81002
Y0121 - Lab Urinalysis with Microscopic	81000
Y0122 - Lab PKU	84030
Y0123 - Lab Hypothyroidism	84435, 84439
Y0124 - Lab Lead Blood	83655
Y0125 - Lab G. C. Culture	87070, 87072, 87075
Y0126 - Lab Pap Smear	88150, 88151, P3000, P3001
Y0127 - Lab Lead EP (finger)	83645
Y0128 - Lab Coproporphyrin, Urine	84118
Y0129 - Lab Handling Fee	99000
Y0113 - HIB	90737

D1022365

TN No. 93-08 DATE/RECEIPT 5-5-93
SUPERSEDES DATE/APPROVED 6-14-93
TN No. _____ DATE/EFFECTIVE 7-1-93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

EPSDT Procedure Code Rates

Description	Code	Rate
Screening 0-2 years	Y0100	$12.00
Screening 3-11 years	Y0102	$14.00
Screening 12-20 years	Y0103	$18.00
Examination and Diagnosis by Physician	Y0104	$ 5.00
Developmental Assessment	Y0105	$11.00
Immunization DPT	Y0106	$20.90
Immunization MMR	Y0107	$39.00
Immunization MR	Y0108	$25.35
Immunization Measles	Y0109	$18.15
Immunization Rubella	Y0114	$18.70
Immunization Mumps	Y0110	$20.00
Immunization TOPV	Y0111	$14.60
Immunization TD or T	Y0112	$ 4.00
Lab Hemoglobin	Y0116	$ 2.25
Lab Hematocrit	Y0117	$ 2.25
Lab Sickle Cell	Y0118	$ 4.50
Lab TB Skin Test	Y0119	$ 4.05
Lab Urinalysis without Microscopic	Y0120	$ 4.50
Lab Urinalysis with Microscopic	Y0121	$ 4.50
Lab PKU	Y0122	$ 6.30
Lab Hypothyroidism	Y0123	$11.25
Lab Lead Blood	Y0124	$17.10
Lab G.C. Culture	Y0125	$ 3.00
Lab Pap Smear	Y0126	$ 4.95
Lab Lead EP (finger)	Y0127	$ 4.05
Lab Coproporphyrin, Urine	Y0128	$ 4.95
Lab Handling Fee	Y0129	$ 3.00
Lab HIB	Y0113	$22.00

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90000	$21.45	$22.71
2.	Clarksville, TN	90000	No billing received	$23.00
3.	Johnson City-Kingsport-Bristol, TN	90000	22.18	22.97
4.	Knoxville, TN	90000	15.50	22.70
5.	Memphis, TN	90000	21.31	22.78
6.	Nashville-Davidson, TN	90000	16.94	21.24
7.	Jackson, TN	90000	23.00	23.00
8.	Non-MSA Counties	90000	21.85	22.79

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90010	$29.79	$29.84
2.	Clarksville, TN	90010	30.00	30.00
3.	Johnson City-Kingsport-Bristol, TN	90010	29.74	29.82
4.	Knoxville, TN	90010	29.62	29.86
5.	Memphis, TN	90010	29.57	30.00
6.	Nashville-Davidson, TN	90010	28.39	29.65
7.	Jackson, TN	90010	30.00	30.00
8.	Non-MSA Counties	90010	29.81	29.67

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90015	$35.32	$39.46
2.	Clarksville, TN	90015	40.00	36.50
3.	Johnson City-Kingsport-Bristol, TN	90015	36.84	37.81
4.	Knoxville, TN	90015	39.71	36.21
5.	Memphis, TN	90015	39.32	39.87
6.	Nashville-Davidson, TN	90015	38.48	38.88
7.	Jackson, TN	90015	39.98	39.64
8.	Non-MSA Counties	90015	38.29	38.67

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90017	$49.67	$48.57
2.	Clarksville, TN	90017	49.53	50.00
3.	Johnson City-Kingsport-Bristol, TN	90017	46.87	49.81
4.	Knoxville, TN	90017	47.17	48.79
5.	Memphis, TN	90017	48.91	50.00
6.	Nashville-Davidson, TN	90017	46.90	49.34
7.	Jackson, TN	90017	49.80	50.00
8.	Non-MSA Counties	90017	45.47	49.42

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90020	$59.79	$55.09
2.	Clarksville, TN	90020	60.00	60.00
3.	Johnson City-Kingsport-Bristol, TN	90020	51.04	57.67
4.	Knoxville, TN	90020	56.21	59.60
5.	Memphis, TN	90020	44.48	59.74
6.	Nashville-Davidson, TN	90020	53.73	59.28
7.	Jackson, TN	90020	58.68	60.00
8.	Non-MSA Counties	90020	55.14	58.30

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90030	$ 8.82	$ 6.83
2.	Clarksville, TN	90030	9.00	9.00
3.	Johnson City-Kingsport-Bristol, TN	90030	8.50	9.00
4.	Knoxville, TN	90030	8.96	9.00
5.	Memphis, TN	90030	8.66	9.00
6.	Nashville-Davidson, TN	90030	8.02	8.24
7.	Jackson, TN	90030	8.99	8.91
8.	Non-MSA Counties	90030	8.85	8.85

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Attachment 4.19-B

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90040	$17.91	$18.00
2.	Clarksville, TN	90040	17.58	18.00
3.	Johnson City-Kingsport-Bristol, TN	90040	17.83	17.97
4.	Knoxville, TN	90040	16.75	17.74
5.	Memphis, TN	90040	17.73	18.00
6.	Nashville-Davidson, TN	90040	17.43	17.74
7.	Jackson, TN	90040	17.94	17.98
8.	Non-MSA Counties	90040	17.47	17.85

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90050	$21.83	$21.82
2.	Clarksville, TN	90050	21.95	21.98
3.	Johnson City-Kingsport-Bristol, TN	90050	21.85	21.84
4.	Knoxville, TN	90050	21.66	21.94
5.	Memphis, TN	90050	21.89	22.00
6.	Nashville-Davidson, TN	90050	21.90	21.88
7.	Jackson, TN	90050	21.98	21.98
8.	Non-MSA Counties	90050	21.82	21.87

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90060	$26.75	$26.48
2.	Clarksville, TN	90060	26.50	27.00
3.	Johnson City-Kingsport-Bristol, TN	90060	26.72	26.41
4.	Knoxville, TN	90060	26.90	26.49
5.	Memphis, TN	90060	26.93	26.98
6.	Nashville-Davidson, TN	90060	26.87	26.86
7.	Jackson, TN	90060	26.98	26.77
8.	Non-MSA Counties	90060	26.73	26.77

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90070	$31.82	$31.75
2.	Clarksville, TN	90070	31.73	32.00
3.	Johnson City-Kingsport-Bristol, TN	90070	30.38	31.73
4.	Knoxville, TN	90070	30.80	31.97
5.	Memphis, TN	90070	31.39	32.00
6.	Nashville-Davidson, TN	90070	31.90	31.59
7.	Jackson, TN	90070	31.70	32.00
8.	Non-MSA Counties	90070	29.80	31.76

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90080	$36.36	37.00
2.	Clarksville, TN	90080	37.00	37.00
3.	Johnson City-Kingsport-Bristol, TN	90080	32.08	36.77
4.	Knoxville, TN	90080	36.81	36.96
5.	Memphis, TN	90080	32.45	37.00
6.	Nashville-Davidson, TN	90080	36.28	36.93
7.	Jackson, TN	90080	36.54	37.00
8.	Non-MSA Counties	90080	32.94	36.96

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90500	$20.40	$24.69
2.	Clarksville, TN	90500	No billing received	25.50
3.	Johnson City-Kingsport-Bristol, TN	90500	25.50	20.57
4.	Knoxville, TN	90500	20.12	20.40
5.	Memphis, TN	90500	No billing received	20.62
6.	Nashville-Davidson, TN	90500	No billing received	21.80
7.	Jackson, TN	90500	No billing received	20.40
8.	Non-MSA Counties	90500	20.63	20.29

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90505	$20.90	$39.32
2.	Clarksville, TN	90505	No billing received	37.29
3.	Johnson City-Kingsport-Bristol, TN	90505	32.50	29.50
4.	Knoxville, TN	90505	20.90	20.73
5.	Memphis, TN	90505	20.90	30.55
6.	Nashville-Davidson, TN	90505	39.16	28.56
7.	Jackson, TN	90505	No billing received	20.90
8.	Non-MSA Counties	90505	23.78	21.31

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90510	$25.40	$32.30
2.	Clarksville, TN	90510	No billing received	32.30
3.	Johnson City-Kingsport-Bristol, TN	90510	27.12	30.39
4.	Knoxville, TN	90510	25.39	25.43
5.	Memphis, TN	90510	27.90	25.80
6.	Nashville-Davidson, TN	90510	32.23	31.94
7.	Jackson, TN	90510	No billing received	26.19
8.	Non-MSA Counties	90510	29.16	27.03

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90515	$35.40	$46.75
2.	Clarksville, TN	90515	No billing received	59.50
3.	Johnson City-Kingsport-Bristol, TN	90515	41.75	51.09
4.	Knoxville, TN	90515	34.33	35.61
5.	Memphis, TN	90515	39.16	37.25
6.	Nashville-Davidson, TN	90515	59.50	49.36
7.	Jackson, TN	90515	No billing received	35.84
8.	Non-MSA Counties	90515	42.71	49.67

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90517	$91.80	$69.19
2.	Clarksville, TN	90517	No billing received	91.80
3.	Johnson City-Kingsport-Bristol, TN	90517	91.80	89.16
4.	Knoxville, TN	90517	91.22	83.46
5.	Memphis, TN	90517	76.76	73.06
6.	Nashville-Davidson, TN	90517	88.35	66.00
7.	Jackson, TN	90517	No billing received	91.80
8.	Non-MSA Counties	90517	84.67	81.78

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90520	$75.00	$78.00
2.	Clarksville, TN	90520	No billing received	78.00
3.	Johnson City-Kingsport-Bristol, TN	90520	67.40	75.96
4.	Knoxville, TN	90520	31.07	31.20
5.	Memphis, TN	90520	78.00	62.40
6.	Nashville-Davidson, TN	90520	76.50	47.71
7.	Jackson, TN	90520	32.00	31.20
8.	Non-MSA Counties	90520	64.14	64.17

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90530*	No billing received	14.60
2.	Clarksville, TN	90530	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	90530	18.20	18.20
4.	Knoxville, TN	90530	No billing received	30.00
5.	Memphis, TN	90530	No billing received	14.60
6.	Nashville-Davidson, TN	90530	25.31	24.39
7.	Jackson, TN	90530	No billing received	20.00
8.	Non-MSA Counties	90530	14.60	14.84

*This service is generally rendered by emergency room physicians rather than pediatricians.

Attachment 4.19-B

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90540	$19.97	$20.58
2.	Clarksville, TN	90540	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	90540	20.50	20.56
4.	Knoxville, TN	90540	19.86	20.54
5.	Memphis, TN	90540	20.00	20.40
6.	Nashville-Davidson, TN	90540	20.25	20.44
7.	Jackson, TN	90540	20.40	20.40
8.	Non-MSA Counties	90540	20.51	20.40

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90550	$20.00	$25.59
2.	Clarksville, TN	90550	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	90550	26.06	26.83
4.	Knoxville, TN	90550	25.48	25.41
5.	Memphis, TN	90550	25.50	25.50
6.	Nashville-Davidson, TN	90550	29.27	27.37
7.	Jackson, TN	90550	26.71	26.09
8.	Non-MSA Counties	90550	28.86	26.22

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90560	$45.83	$38.66
2.	Clarksville, TN	90560	21.68	No billing received
3.	Johnson City-Kingsport-Bristol, TN	90560	40.38	36.88
4.	Knoxville, TN	90560	25.00	44.96
5.	Memphis, TN	90560	29.34	46.46
6.	Nashville-Davidson, TN	90560	22.30	39.12
7.	Jackson, TN	90560	29.10	49.77
8.	Non-MSA Counties	90560	28.19	38.12

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90570	$31.66	$31.83
2.	Clarksville, TN	90570	29.75	No Billing Received
3.	Johnson City-Kingsport-Bristol, TN	90570	31.66	31.40
4.	Knoxville, TN	90570	26.12	30.08
5.	Memphis, TN	90570	29.88	31.70
6.	Nashville-Davidson, TN	90570	29.83	31.63
7.	Jackson, TN	90570	29.75	31.37
8.	Non-MSA Counties	90570	29.42	31.15

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90580	$43.64	$36.20
2.	Clarksville, TN	90580	No Billing Received	No Billing Received
3.	Johnson City-Kingsport-Bristol, TN	90580	25.00	53.00
4.	Knoxville, TN	90580	46.14	65.00
5.	Memphis, TN	90580	50.00	No Billing Received
6.	Nashville-Davidson, TN	90580	65.00	64.30
7.	Jackson, TN	90580	65.00	No Billing Received
8.	Non-MSA Counties	90580	64.29	47.57

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90701	$16.41	No Billing Received
2.	Clarksville, TN	90701	16.24	16.45
3.	Johnson City-Kingsport-Bristol, TN	90701	16.45	16.30
4.	Knoxville, TN	90701	16.37	16.40
5.	Memphis, TN	90701	16.43	12.94
6.	Nashville-Davidson, TN	90701	16.43	16.44
7.	Jackson, TN	90701	16.45	9.94
8.	Non-MSA Counties	90701	16.23	16.16

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90702	$ 2.00	No Billing Received
2.	Clarksville, TN	90702	2.00	$ 2.00
3.	Johnson City-Kingsport-Bristol, TN	90702	2.00	2.00
4.	Knoxville, TN	90702	2.00	2.00
5.	Memphis, TN	90702	2.00	2.00
6.	Nashville-Davidson, TN	90702	2.00	2.00
7.	Jackson, TN	90702	2.00	2.00
8.	Non-MSA Counties	90702	2.00	2.00

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90704*	$18.00	No billing received
2.	Clarksville, TN	90704	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	90704	No billing received	$18.00
4.	Knoxville, TN	90704	No billing received	No billing received
5.	Memphis, TN	90704	$18.00	No billing received
6.	Nashville-Davidson, TN	90704	4.50	No billing received
7.	Jackson, TN	90704	No billing received	No billing received
8.	Non-MSA Counties	90704	18.00	18.00

*90704 - This service is generally provided thorugh the EPSDT program which has separate procedure codes.

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90705*	No billing received	No billing received
2.	Clarksville, TN	90705	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol	90705	No billing received	No billing received
4.	Knoxville, TN	90705	No billing received	$16.15
5.	Memphis, TN	90705	$16.15	16.15
6.	Nashville-Davidson, TN	90705	No billing received	No billing received
7.	Jackson, TN	90705	No billing received	No billing received
8.	Non-MSA Counties	90705	16.15	No billing received

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90706*	No billing received	No billing received
2.	Clarksville, TN	90706	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol	90706	No billing received	No billing received
4.	Knoxville, TN	90706	No billing received	No billing received
5.	Memphis, TN	90706	$16.70	No billing received
6.	Nashville-Davidson, TN	90706	No billing received	$16.70
7.	Jackson, TN	90706	No billing received	No billing received
8.	Non-MSA Counties	90706	16.70	16.70

*90705 and 90706 - These services are generally provided through the EPSDT program which has separate procedure codes.

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PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90707	$35.07	No billing received
2.	Clarksville, TN	90707	32.93	No billing received
3.	Johnson City-Kingsport-Bristol	90707	35.42	$26.65
4.	Knoxville, TN	90707	35.21	35.33
5.	Memphis, TN	90707	35.25	25.18
6.	Nashville-Davidson, TN	90707	34.80	35.51
7.	Jackson, TN	90707	36.42	34.17
8.	Non-MSA Counties	90707	33.72	34.49

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90708*	No billing received	No billing received
2.	Clarksville, TN	90708	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol	90708	No billing received	No billing received
4.	Knoxville, TN	90708	No billing received	No billing received
5.	Memphis, TN	90708	No billing received	No billing received
6.	Nashville-Davidson, TN	90708	No billing received	No billing received
7.	Jackson, TN	90708	No billing received	No billing received
8.	Non-MSA Counties	90708	$23.35	$23.35

*90708 - This service is generally provided through the EPSDT program which has separate procedure codes.

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90709*	No billing received	No billing received
2.	Clarksville, TN	90709	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol	90709	No billing received	No billing received
4.	Knoxville, TN	90709	No billing received	No billing received
5.	Memphis, TN	90709	No billing received	No billing received
6.	Nashville-Davidson, TN	90709	No billing received	No billing received
7.	Jackson, TN	90709	No billing received	No billing received
8.	Non-MSA Counties	90709	No billing received	No billing received

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90712	$12.58	No billing received
2.	Clarksville, TN	90712	12.60	$12.60
3.	Johnson City-Kingsport-Bristol	90712	12.60	12.60
4.	Knoxville, TN	90712	12.52	12.57
5.	Memphis, TN	90712	12.54	11.57
6.	Nashville-Davidson, TN	90712	12.59	12.59
7.	Jackson, TN	90712	No billing received	8.80
8.	Non-MSA Counties	90712	12.59	12.51

*90709 - This service is generally provided through the EPSDT program which has separate procedure codes.

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PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90737	$19.99	No billing received
2.	Clarksville, TN	90737	20.00	$20.00
3.	Johnson City-Kingsport-Bristol	90737	19.96	19.41
4.	Knoxville, TN	90737	19.97	19.92
5.	Memphis, TN	90737	19.99	13.53
6.	Nashville-Davidson, TN	90737	19.98	19.93
7.	Jackson, TN	90737	19.90	10.76
8.	Non-MSA Counties	90737	19.94	19.25

90751-90764*

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	90774	$32.05	No billing received
2.	Clarksville, TN	90774	No billing received	No billing received
3.	Johnson City-Kingsport	90774	21.65	No billing received
4.	Knoxville, TN	90774	20.22	No billing received
5.	Memphis, TN	90774	35.66	18.20
6.	Nashville-Davidson, TN	90774	2.93	12.42
7.	Jackson, TN	90774	30.00	15.00
8.	Non-MSA Counties	90774	28.37	43.57

*These services are covered only through the EPSDT program.

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

90778*

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0100	$11.70	$12.00
2.	Clarksville, TN	Y0100	11.99	12.00
3.	Johnson City-Kingsport-Bristol	Y0100	11.92	11.37
4.	Knoxville, TN	Y0100	11.78	11.96
5.	Memphis, TN	Y0100	11.98	11.83
6.	Nashville-Davidson, TN	Y0100	11.91	11.95
7.	Jackson, TN	Y0100	12.00	12.00
8.	Non-MSA Counties	Y0100	11.85	11.91

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0102	$13.73	$14.00
2.	Clarksville, TN	Y0102	13.96	13.83
3.	Johnson City-Kingsport-Bristol	Y0102	13.91	13.09
4.	Knoxville, TN	Y0102	13.80	13.95
5.	Memphis, TN	Y0102	13.94	13.84
6.	Nashville-Davidson, TN	Y0102	13.87	14.00
7.	Jackson, TN	Y0102	14.00	14.00
8.	Non-MSA Counties	Y0102	13.75	13.83

*90778 - This service is not covered.

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0103	$16.18	$17.00
2.	Clarksville, TN	Y0103	18.00	16.00
3.	Johnson City-Kingsport-Bristol	Y0103	17.89	16.52
4.	Knoxville, TN	Y0103	17.50	17.20
5.	Memphis, TN	Y0103	17.97	18.00
6.	Nashville-Davidson, TN	Y0103	17.83	18.00
7.	Jackson, TN	Y0103	No billing received	18.00
8.	Non-MSA Counties	Y0103	17.60	17.81

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0104	$ 4.99	$ 5.00
2.	Clarksville, TN	Y0104	5.00	5.00
3.	Johnson City-Kingsport-Bristol	Y0104	4.99	5.00
4.	Knoxville, TN	Y0104	4.99	5.00
5.	Memphis, TN	Y0104	5.00	5.00
6.	Nashville-Davidson, TN	Y0104	5.00	4.98
7.	Jackson, TN	Y0104	5.00	5.00
8.	Non-MSA Counties	Y0104	4.99	4.99

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0105	$10.91	$11.00
2.	Clarksville, TN	Y0105	10.99	10.63
3.	Johnson City-Kingsport-Bristol	Y0105	10.95	10.99
4.	Knoxville, TN	Y0105	10.99	10.89
5.	Memphis, TN	Y0105	10.99	10.95
6.	Nashville-Davidson, TN	Y0105	10.87	11.00
7.	Jackson, TN	Y0105	11.00	11.00
8.	Non-MSA Counties	Y0105	10.87	10.99

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0106	$18.30	$18.45
2.	Clarksville, TN	Y0106	18.46	18.34
3.	Johnson City-Kingsport-Bristol	Y0106	18.34	18.39
4.	Knoxville, TN	Y0106	18.28	18.18
5.	Memphis, TN	Y0106	18.00	5.52
6.	Nashville-Davidson, TN	Y0106	18.11	17.71
7.	Jackson, TN	Y0106	18.52	18.25
8.	Non-MSA Counties	Y0106	17.96	18.37

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0107	$34.34	$34.53
2.	Clarksville, TN	Y0107	35.41	35.96
3.	Johnson City-Kingsport-Bristol	Y0107	34.49	34.57
4.	Knoxville, TN	Y0107	34.77	35.69
5.	Memphis, TN	Y0107	34.95	8.78
6.	Nashville-Davidson, TN	Y0107	35.12	34.96
7.	Jackson, TN	Y0107	No billing received	35.83
8.	Non-MSA Counties	Y0107	34.62	35.30

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0108*	$ 3.00	No billing received
2.	Clarksville, TN	Y0108	No billing received	No billing received
3.	Johnson City-Kingsport-	Y0108	No billing received	No billing received
4.	Knoxville, TN	Y0108	25.35	No billing received
5.	Memphis, TN	Y0108	25.35	$ 8.00
6.	Nashville-Davidson, TN	Y0108	No billing received	No billing received
7.	Jackson, TN	Y0108	No billing received	No billing received
8.	Non-MSA Counties	Y0108	25.35	25.35

*Y0108 - Most children receive the MMR rather than the MR immunization.

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga,TN	Y0109*	$18.15	No billing received
2.	Clarksville, TN	Y0109	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol	Y0109	No billing received	$17.00
4.	Knoxville, TN	Y0109	18.15	No billing received
5.	Memphis, TN	Y0109	9.38	5.34
6.	Nashville-Davidson, TN	Y0109	15.07	No billing received
7.	Jackson, TN	Y0109	No billing received	No billing received
8.	Non-MSA Counties	Y0109	No billing received	No billing received

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0110*	$20.00	$20.00
2.	Clarksville, TN	Y0110	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0110	20.00	No billing received
4.	Knoxville, TN	Y0110	17.14	No billing received
5.	Memphis, TN	Y0110	20.00	5.00
6.	Nashville-Davidson, TN	Y0110	17.30	15.00
7.	Jackson, TN	Y0110	No billing received	No billing received
8.	Non-MSA Counties	Y0110	16.11	20.00

*Y0109 and Y0110 - Most children receive the MMR rather than the separate immunizations.

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0111	$14.59	$14.60
2.	Clarksville, TN	Y0111	14.59	14.52
3.	Johnson City-Kingsport-Bristol, TN	Y0111	14.58	14.51
4.	Knoxville, TN	Y0111	14.43	13.73
5.	Memphis, TN	Y0111	14.25	5.51
6.	Nashville-Davidson, TN	Y0111	14.33	14.59
7.	Jackson, TN	Y0111	14.60	14.47
8.	Non-MSA Counties	Y0111	14.42	14.54

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0112	$ 3.87	$ 4.00
2.	Clarksville, TN	Y0112	4.00	4.00
3.	Johnson City-Kingsport-Bristol, TN	Y0112	4.00	4.00
4.	Knoxville, TN	Y0112	4.00	4.00
5.	Memphis, TN	Y0112	3.97	4.00
6.	Nashville-Davidson, TN	Y0112	3.97	4.00
7.	Jackson, TN	Y0112	No billing received	4.00
8.	Non-MSA Counties	Y0112	3.99	4.00

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PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0113	$21.98	$22.00
2.	Clarksville, TN	Y0113	21.91	21.37
3.	Johnson City-Kingsport-Bristol, TN	Y0113	21.66	18.60
4.	Knoxville, TN	Y0113	21.83	21.05
5.	Memphis, TN	Y0113	21.43	5.28
6.	Nashville-Davidson, TN	Y0113	21.59	21.88
7.	Jackson, TN	Y0113	22.00	21.97
8.	Non-MSA Counties	Y0113	21.66	21.84

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0114*	No billing received	No billing received
2.	Clarksville, TN	Y0114	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0114	No billing received	No billing received
4.	Knoxville, TN	Y0114	No billing received	No billing received
5.	Memphis, TN	Y0114	No billing received	5.00
6.	Nashville-Davidson, TN	Y0114	No billing received	No billing received
7.	Jackson, TN	Y0114	No billing received	No billing received
8.	Non-MSA Counties	Y0114	No billing received	No billing received

*Y0114 - Most children receive the MMR rather than the separate immunization.

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0116	$2.25	$2.25
2.	Clarksville, TN	Y0116	2.25	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0116	2.25	2.25
4.	Knoxville, TN	Y0116	2.25	2.25
5.	Memphis, TN	Y0116	2.25	2.25
6.	Nashville-Davidson, TN	Y0116	2.24	2.25
7.	Jackson, TN	Y0116	No billing received	2.25
8.	Non-MSA Counties	Y0116	2.24	2.25

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0117	$ 2.25	No billing received
2.	Clarksville, TN	Y0117	2.25	$ 2.25
3.	Johnson City-Kingsport-Bristol, TN	Y0117	2.25	2.25
4.	Knoxville, TN	Y0117	2.25	2.25
5.	Memphis, TN	Y0117	2.25	2.25
6.	Nashville-Davidson, TN	Y0117	2.25	2.25
7.	Jackson, TN	Y0117	No billing received	2.25
8.	Non-MSA Counties	Y0117	2.24	2.25

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PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0118	$ 4.50	No billing received
2.	Clarksville, TN	Y0118	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0118	4.50	No billing received
4.	Knoxville, TN	Y0118	4.28	4.50
5.	Memphis, TN	Y0118	4.50	4.50
6.	Nashville-Davidson, TN	Y0118	4.21	No billing received
7.	Jackson, TN	Y0118	No billing received	4.50
8.	Non-MSA Counties	Y0118	3.88	4.50

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0119	$ 4.03	$ 4.05
2.	Clarksville, TN	Y0119	4.05	4.05
3.	Johnson City-Kingsport-Bristol, TN	Y0119	4.05	4.05
4.	Knoxville, TN	Y0119	4.04	4.05
5.	Memphis, TN	Y0119	4.04	4.05
6.	Nashville-Davidson, TN	Y0119	3.93	4.05
7.	Jackson, TN	Y0119	4.05	4.05
8.	Non-MSA Counties	Y0119	4.04	4.05

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0120	$ 4.50	$ 4.50
2.	Clarksville, TN	Y0120	4.50	4.50
3.	Johnson City-Kingsport-Bristol, TN	Y0120	4.50	4.50
4.	Knoxville, TN	Y0120	4.49	4.50
5.	Memphis, TN	Y0120	4.44	4.50
6.	Nashville-Davidson, TN	Y0120	4.49	3.44
7.	Jackson, TN	Y0120	No billing received	4.03
8.	Non-MSA Counties	Y0120	4.47	4.45

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0121	$ 4.50	No billing received
2.	Clarksville, TN	Y0121	4.50	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0121	4.50	4.50
4.	Knoxville, TN	Y0121	4.50	4.50
5.	Memphis, TN	Y0121	4.50	4.50
6.	Nashville-Davidson, TN	Y0121	4.50	4.45
7.	Jackson, TN	Y0121	No billing received	4.48
8.	Non-MSA Counties	Y0121	4.49	4.49

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0122*	$ 6.30	No billing received
2.	Clarksville, TN	Y0122	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0122	6.30	No billing received
4.	Knoxville, TN	Y0122	6.03	No billing received
5.	Memphis, TN	Y0122	5.05	No billing received
6.	Nashville-Davidson, TN	Y0122	5.81	No billing received
7.	Jackson, TN	Y0122	No billing received	No billing received
8.	Non-MSA Counties	Y0122	4.32	No billing received

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0123*	No billing received	No billing received
2.	Clarksville, TN	Y0123	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0123	$11.25	No billing received
4.	Knoxville, TN	Y0123	8.00	No billing received
5.	Memphis, TN	Y0123	4.00	No billing received
6.	Nashville-Davidson, TN	Y0123	No billing received	No billing received
7.	Jackson, TN	Y0123	No billing received	No billing received
8.	Non-MSA Counties	Y0123	No billing received	No billing received

*Y0122 and Y0123 - These services are generally included in the inpatient hospital costs for newborns.

Attachment 4.19-B

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0124*	No billing received	No billing received
2.	Clarksville, TN	Y0124	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0124	$16.50	No billing received
4.	Knoxville, TN	Y0124	9.84	No billing received
5.	Memphis, TN	Y0124	17.10	No billing received
6.	Nashville-Davidson, TN	Y0124	13.14	No billing received
7.	Jackson, TN	Y0124	No billing received	No billing received
8.	Non-MSA Counties	Y0124	4.74	15.32

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0125	No billing received	No billing received
2.	Clarksville, TN	Y0125	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0125	No billing received	$3.00
4.	Knoxville, TN	Y0125	$3.00	No billing received
5.	Memphis, TN	Y0125	3.00	3.00
6.	Nashville-Davidson, TN	Y0125	3.00	No billing received
7.	Jackson, TN	Y0125	No billing received	No billing received
8.	Non-MSA Counties	Y0125	3.00	No billing received

* Y0124 - This service is generally provided by independent laboratories.

Attachment 4.19-B

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0126	No billing received	No billing received
2.	Clarksville, TN	Y0126	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0126	No billing received	4.95
4.	Knoxville, TN	Y0126	$ 4.95	No billing received
5.	Memphis, TN	Y0126	4.95	4.95
6.	Nashville-Davidson, TN	Y0126	4.95	No billing received
7.	Jackson, TN	Y0126	No billing received	No billing received
8.	Non-MSA Counties	Y0126	4.95	$4.95

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0127	No billing received	No billing received
2.	Clarksville, TN	Y0127	$ 4.05	No billing received
3.	Johnson City-Kingsport-Bristol, TN	Y0127	No billing received	No billing received
4.	Knoxville, TN	Y0127	3.94	4.05
5.	Memphis, TN	Y0127	4.05	No billing received
6.	Nashville-Davidson, TN	Y0127	3.90	No billing received
7.	Jackson, TN	Y0127	No billing received	No billing received
8.	Non-MSA Counties	Y0127	$3.17	$4.05

TN No. 93-08
Supersedes
TN No. 92-38

Approval Date JUN 14 1993

Effective Date 7/1/93

PEDIATRIC SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0128	No billing received	No billing received
2.	Clarksville, TN	Y0128	No billing received	No billing received
3.	Johnson City-Kingsport-Bristol	Y0128	No billing received	No billing received
4.	Knoxville, TN	Y0128	$ 4.95	No billing received
5.	Memphis, TN	Y0128	No billing received	No billing received
6.	Nashville-Davidson, TN	Y0128	4.95	$ 3.00
7.	Jackson, TN	Y0128	No billing received	No billing received
8.	Non-MSA Counties	Y0128	No billing received	4.95

MSA		PROCEDURE	Pediatrician	Family Practitioner
1.	Chattanooga, TN	Y0129	No billing received	No billing received
2.	Clarksville, TN	Y0129	$ 3.00	$ 2.97
3.	Johnson City-Kingsport-Bristol	Y0129	3.00	3.00
4.	Knoxville, TN	Y0129	3.00	3.00
5.	Memphis, TN	Y0129	3.00	3.00
6.	Nashville-Davidson, TN	Y0129	2.99	3.00
7.	Jackson, TN	Y0129	No billing received	3.00
8.	Non-MSA Counties	Y0129	3.00	3.00

D3013097

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

5(b) Payment for Obstetrical Services

1. Maternity Care and Delivery

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
		INCISION	
59020	59020	Fetal oxytocin stress test	$ 25.50
59025	59025	Fetal non-stress test	$ 15.00
59030	59030	Fetal scalp blood sampling	$ 27.00
59031	---	Repeat	---
59050	59050	Initiation and/or supervision of internal fetal monitoring during labor by consultant	$ 42.50
		REPAIR	
59300	59300	Episiotomy or vaginal repair only, by other than attending physician; simple	$164.00
59305	---	extensive	---
		DELIVERY, ANTEPARTUM AND POSTPARTUM CARE	
59400	59400	Total obstetric care (all-inclusive, "global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care	$1,100.00
59410	59410	Vaginal delivery only (with or without episiotomy, forceps or breech delivery including in-hospital postpartum care) (separate procedure)	$725.00
59412	59412	External cephalic version, with or without tocoplyis	$100.00
---	59414	Delivery of placenta following delivery of infant outside of hospital	$297.50
59420	59420	Antepartum care visits up to a total of $375.00	$375.00
59430	59430	Postpartum care only (separate procedure)	$ 50.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

5(b) Continued.

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
		CESAREAN SECTION	
59500	---	Cesarean section, low cervical, including in-hospital postpartum care; (separate procedure)	---
59501	---	including antepartum and postpartum care	---
---	59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1,300.00
---	59515	Cesarean delivery only including postpartum care	$925.00
59520	---	Cesarean section, classic, including in-hospital postpartum care; (separate procedure)	---
59521	---	including antepartum and postpartum care	---
---	59525	Subtotal or total hysterectomy after cesarean delivery (list in addition to 59510 and 59515)	$518.00
59540	---	Cesarean section, extraperitoneal, including in-hospital postpartum care; (separate procedure)	---
59541	---	including antepartum and postpartum care	---
59560	---	Cesarean section with hysterectomy, subtotal, including in-hospital postpartum care; (separate procedure)	---
59561	---	including antepartum and postpartum care	---
59580	---	Cesarean section with hysterectomy, total, including in-hospital postpartum care; (separate procedure)	---
59581	---	including antepartum and postpartum care	---
		ABORTION	
59800	*	Treatment of spontaneous abortion, first trimester; completed medically	---
59801	---	completed surgically (separate procedure)	---
59810	*	Treatment of spontaneous abortion, second trimester; completed medically	---

* See Section on Office and Other Outpatient Services

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

5(b) Continued.

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
59811	---	completed surgically (separate procedure)	---
---	59812	Treatment of spontaneous abortion, any trimester, completed surgically	$382.50
59820	59820	Treatment of missed abortion, completed surgically; first trimester	$340.00
---	59821	second trimester	$382.50
59830	59830	Treatment of septic abortion, completed surgically	$382.50
	2. Diagnostic Ultrasound		
		PELVIS	
76805	76805	Echography, pregnant uterus, B-scan and/or real time with oimage documentation; complete	$ 80.75
76815	76815	limited (fetal growth rate, heart beat, anomalies, placental location)	$ 68.96
76816	76816	follow-up or repeat	$ 82.45
76818	76818	Fetal biophysical profile	$ 50.00
76825	76825	Echocardiography, fetal heart in utero	$292.50
76855	76855	Echography, pelvic area (Doppler)	$ 58.82

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

* Office or Other Outpatient Services

NEW PATIENT

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
59800 and 59810	99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: . a problem focused history; . a problem focused examination; and . straightforward medical decision making.	$23.00
59800 and 59810	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: . an expanded problem focused history; . an expanded problem focused examination; and . straightforward medical decision making.	$30.00
59800 and 59810	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: . a detailed history; . a detailed examination; and . medical decision making of low complexity.	$40.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Office and Other Outpatient Services (continued)

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
59800 and 59810	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: . a comprehensive history; . a comprehensive examination; and . medical decision making of moderate complexity.	$50.00
59800 and 59810	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: . a comprehensive history; . a comprehensive examination; and . medical decision making of high complexity.	$60.00
		ESTABLISHED PATIENT	
59800 and 59810	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	$9.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
59800 and 59810	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: . a problem focused history; . a problem focused examination; . straightforward medical decision making.	$18.00
59800 and 59810	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: . an expanded problem focused history; . an expanded problem focused examination; . medical decision making of low complexity.	$22.00
59800 and 59810	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: . a detailed history; . a detailed examination; . medical decision making of moderate complexity.	$32.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
59800 and 59810	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: . a comprehensive history; . a comprehensive examination; . medical decision making of high complexity.	$37.00
		Hospital Inpatient Services INITIAL HOSPITAL CARE	
59800 and 59810	99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: . a detailed or comprehensive history; . a detailed or comprehensive examination; and . medical decision making that is straightforward or of low complexity.	$27.71
59800 and 59810	99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: . a comprehensive history; . a comprehensive examination; and . medical decision making of moderate complexity.	$44.88

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

1990 Procedure Code	1993 Procedure Code		1993 Maximum Rate
		Subsequent Hospital Care	
59800 and 59810	99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: . a problem focused interval history; . a problem focused examination; . medical decision making that is straightforward or of low complexity.	$14.79
59800 and 59810	99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: . an expanded problem focused interval history; . an expanded problem focused examination; . medical decision making of moderate complexities.	$18.62
59800 and 59810	99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: . a detailed interval history; . a detailed examination; . medical decision making of high complexity.	$34.77

D1013085

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59020	24.22	No billing received	No billing received
2.	Clarksville, TN	59020	19.12	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59020	15.54	25.68	No billing received
4.	Knoxville, TN	59020	22.61	No billing received	No billing received
5.	Memphis, TN	59020	20.73	19.26	No billing received
6.	Nashville - Davidson, TN	59020	25.50	No billing received	No billing received
7.	Jackson, TN	59020	No billing received	No billing received	No billing received
8.	Non-MSA Counties	59020	25.24	24.69	No billing received
1.	Chattanooga, TN	59025	14.90	No billing received	No billing received
2.	Clarksville, TN	59025	14.91	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59025	14.87	15.00	15.00
4.	Knoxville, TN	59025	14.05	15.00	No billing received
5.	Memphis, TN	59025	14.87	15.00	No billing received
6.	Nashville - Davidson, TN	59025	13.68	No billing received	No billing received
7.	Jackson, TN	59025	14.62	14.39	14.37
8.	Non-MSA Counties	59025	13.42	14.96	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59030	No billing received	No billing received	No billing received
2.	Clarksville, TN	59030	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59030	27.00	No billing received	No billing received
4.	Knoxville, TN	59030	No billing received	No billing received	No billing received
5.	Memphis, TN	59030	No billing received	No billing received	No billing received
6.	Nashville - Davidson, TN	59030	No billing received	No billing received	No billing received
7.	Jackson, TN	59030	No billing received	No billing received	No billing received
8.	Non-MSA Counties	59030	27.00	No billing received	No billing received
		59031*			
1.	Chattanooga, TN	59050	No billing received	No billing received	No billing received
2.	Clarksville, TN	59050	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59050	32.89	No billing received	No billing received
4.	Knoxville, TN	59050	34.77	No billing received	No billing received
5.	Memphis, TN	59050	14.44	No billing received	No billing received
6.	Nashville - Davidson, TN	59050	41.79	No billing received	No billing received
7.	Jackson, TN	59050	No billing received	No billing received	No billing received
8.	Non-MSA Counties	59050	18.08	23.81	No billing received

*59031 - This code was deleted from CPT-4 effective January 1, 1990.

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59300	No billing received	No billing received	No billing received
2.	Clarksville, TN	59300	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59300	82.00	No billing received	No billing received
4.	Knoxville, TN	59300	143.50	No billing received	No billing received
5.	Memphis, TN	59300	164.00	No billing received	No billing received
6.	Nashville - Davidson, TN	59300	142.66	No billing received	No billing received
7.	Jackson, TN	59300	164.00	No billing received	No billing received
8.	Non-MSA Counties	59300	164.00	147.50	No billing received
			*59305		
1.	Chattanooga, TN	59400	900.30	No billing received	No billing received
2.	Clarksville, TN	59400	1,061.57	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59400	1,038.63	898.94	No billing received
4.	Knoxville, TN	59400	1,042.75	993.95	No billing received
5.	Memphis, TN	59400	1,002.22	1,010.36	No billing received
6.	Nashville - Davidson, TN	59400	1,018.25	983.22	No billing received
7.	Jackson, TN	59400	1,002.70	962.95	No billing received
8.	Non-MSA Counties	59400	1,028.71	997.65	No billing received

*59305 - This code was deleted from CPT-4 effective January 1, 1990.

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59410	640.17	No billing received	No billing received
2.	Clarksville, TN	59410	716.36	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59410	664.32	598.00	No billing received
4.	Knoxville, TN	59410	678.62	700.00	No billing received
5.	Memphis, TN	59410	701.33	633.92	No billing received
6.	Nashville - Davidson, TN	59410	692.40	648.33	No billing received
7.	Jackson, TN	59410	636.63	685.41	457.28
8.	Non-MSA Counties	59410	665.27	638.96	No billing received
1.	Chattanooga, TN	59412	93.75	No billing received	No billing received
2.	Clarksville, TN	59412	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59412	100.00	No billing received	No billing received
4.	Knoxville, TN	59412	97.05	No billing received	No billing received
5.	Memphis, TN	59412	100.00	No billing received	No billing received
6.	Nashville - Davidson, TN	59412	91.66	No billing received	No billing received
7.	Jackson, TN	59412	100.00	100.00	No billing received
8.	Non-MSA Counties	59412	94.44	100.00	No billing received

Attachment 4.19-B

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59420	45.91	97.22	No billing received
2.	Clarksville, TN	59420	71.79	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59420	55.29	68.15	26.78
4.	Knoxville, TN	59420	43.58	56.37	No billing received
5.	Memphis, TN	59420	89.65	108.92	No billing received
6.	Nashville - Davidson, TN	59420	96.08	70.99	No billing received
7.	Jackson, TN	59420	72.07	51.84	38.02
8.	Non-MSA Counties	59420	51.68	26.01	No billing received
1.	Chattanooga, TN	59430	45.00	50.00	No billing received
2.	Clarksville, TN	59430	33.33	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59430	49.80	44.50	No billing received
4.	Knoxville, TN	59430	49.79	50.00	No billing received
5.	Memphis, TN	59430	70.00	50.00	No billing received
6.	Nashville - Davidson, TN	59430	47.75	50.00	No billing received
7.	Jackson, TN	59430	50.00	50.00	No billing received
8.	Non-MSA Counties	59430	48.69	52.45	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59500	No billing received	No billing received	No billing received
2.	Clarksville, TN	59500	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59500	No billing received	No billing received	No billing received
4.	Knoxville, TN	59500	527.50	No billing received	No billing received
5.	Memphis, TN	59500	No billing received	No billing received	No billing received
6.	Nashville - Davidson, TN	59500	646.87	No billing received	No billing received
7.	Jackson, TN	59500	No billing received	No billing received	No billing received
8.	Non-MSA Counties	59500	383.31	576.98	No billing received
1.	Chattanooga, TN	59501	925.00	No billing received	No billing received
2.	Clarksville, TN	59501	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59501	925.00	No billing received	No billing received
4.	Knoxville, TN	59501	925.00	No billing received	No billing received
5.	Memphis, TN	59501	No billing received	No billing received	No billing received
6.	Nashville - Davidson, TN	59501	925.00	No billing received	No billing received
7.	Jackson, TN	59501	No billing received	No billing received	No billing received
8.	Non-MSA Counties	59501	No billing received	850.00	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59510	1,132.38	No billing received	No billing received
2.	Clarksville, TN	59510	1,246.41	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59510	1,223.78	No billing received	No billing received
4.	Knoxville, TN	59510	1,237.43	1,250.00	No billing received
5.	Memphis, TN	59510	1,200.93	1,183.33	No billing received
6.	Nashville - Davidson, TN	59510	1,206.52	No billing received	No billing received
7.	Jackson, TN	59510	1,149.41	1,211.37	No billing received
8.	Non-MSA Counties	59510	1,212.36	1,213.85	No billing received
1.	Chattanooga, TN	59515	851.27	No billing received	No billing received
2.	Clarksville, TN	59515	430.89	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59515	858.06	161.66	No billing received
4.	Knoxville, TN	59515	799.64	228.00	No billing received
5.	Memphis, TN	59515	902.95	204.00	No billing received
6.	Nashville - Davidson, TN	59515	786.75	163.46	No billing received
7.	Jackson, TN	59515	840.28	523.75	No billing received
8.	Non-MSA Counties	59515	633.63	274.68	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
				59520* 59521*	
1.	Chattanooga, TN	59525	No billing received	No billing received	No billing received
2.	Clarksville, TN	59525	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59525	414.40	No billing received	No billing received
4.	Knoxville, TN	59525	518.00	No billing received	No billing received
5.	Memphis, TN	59525	113.96	No billing received	No billing received
6.	Nashville - Davidson, TN	59525	No billing received	No billing received	No billing received
7.	Jackson, TN	59525	No billing received	No billing received	No billing received
8.	Non-MSA Counties	59525	518.00	No billing received	No billing received
				59540* 59541* 59560* 59561* 59580* 59581* 59800*	

*These codes were deleted from CPT-4 effective January 1, 1990.

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
				59801*	
				59810*	
				59811*	
1.	Chattanooga, TN	59812	374.85	No billing received	No billing received
2.	Clarksville, TN	59812	374.65	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59812	361.44	No billing received	No billing received
4.	Knoxville, TN	59812	374.48	No billing received	No billing received
5.	Memphis, TN	59812	371.57	240.00	No billing received
6.	Nashville - Davidson, TN	59812	371.84	371.66	No billing received
7.	Jackson, TN	59812	323.69	382.50	No billing received
8.	Non-MSA Counties	59812	374.75	358.38	No billing received

*These codes were deleted from CPT-4 effective January 1, 1990.

Attachment 4.19-B

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59820	324.29	No billing received	No billing received
2.	Clarksville, TN	59820	340.00	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59820	325.00	No billing received	No billing received
4.	Knoxville, TN	59820	115.78	No billing received	No billing received
5.	Memphis, TN	59820	340.00	No billing received	No billing received
6.	Nashville - Davidson, TN	59820	24.35	No billing received	No billing received
7.	Jackson, TN	59820	254.38	180.00	No billing received
8.	Non-MSA Counties	59820	327.43	180.00	No billing received
1.	Chattanooga, TN	59821	382.50	350.00	No billing received
2.	Clarksville, TN	59821	382.50	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59821	374.37	No billing received	No billing received
4.	Knoxville, TN	59821	380.00	No billing received	No billing received
5.	Memphis, TN	59821	382.50	No billing received	No billing received
6.	Nashville - Davidson, TN	59821	382.50	No billing received	No billing received
7.	Jackson, TN	59821	382.50	No billing received	No billing received
8.	Non-MSA Counties	59821	373.33	300.00	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	59830	375.00	No billing received	No billing received
2.	Clarksville, TN	59830	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	59830	No billing received	No billing received	No billing received
4.	Knoxville, TN	59830	No billing received	No billing received	No billing received
5.	Memphis, TN	59830	382.50	No billing received	No billing received
6.	Nashville - Davidson, TN	59830	382.50	No billing received	No billing received
7.	Jackson, TN	59830	No billing received	No billing received	No billing received
8.	Non-MSA Counties	59830	382.50	250.00	No billing received
1.	Chattanooga, TN	76805	59.19	80.75	No billing received
2.	Clarksville, TN	76805	67.31	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	76805	67.31	44.20	67.32
4.	Knoxville, TN	76805	63.13	80.75	No billing received
5.	Memphis, TN	76805	69.18	80.75	No billing received
6.	Nashville - Davidson, TN	76805	67.06	No billing received	No billing received
7.	Jackson, TN	76805	59.89	80.75	No billing received
8.	Non-MSA Counties	76805	64.28	77.59	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	76815	68.93	No billing received	No billing received
2.	Clarksville, TN	76815	68.96	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	76815	68.01	No billing received	68.96
4.	Knoxville, TN	76815	67.28	68.96	No billing received
5.	Memphis, TN	76815	68.80	68.96	No billing received
6.	Nashville - Davidson, TN	76815	65.59	No billing received	No billing received
7.	Jackson, TN	76815	67.84	68.96	68.96
8.	Non-MSA Counties	76815	67.01	67.64	No billing received
1.	Chattanooga, TN	76816	78.94	No billing received	No billing received
2.	Clarksville, TN	76816	82.45	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	76816	80.22	No billing received	No billing received
4.	Knoxville, TN	76816	80.26	No billing received	No billing received
5.	Memphis, TN	76816	82.32	No billing received	No billing received
6.	Nashville - Davidson, TN	76816	56.03	No billing received	No billing received
7.	Jackson, TN	76816	74.79	82.45	82.45
8.	Non-MSA Counties	76816	78.02	79.59	No billing received

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OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	76818	50.00	No billing received	No billing received
2.	Clarksville, TN	76818	50.00	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	76818	50.00	No billing received	No billing received
4.	Knoxville, TN	76818	50.00	No billing received	No billing received
5.	Memphis, TN	76818	50.00	50.00	No billing received
6.	Nashville - Davidson, TN	76818	50.00	No billing received	No billing received
7.	Jackson, TN	76818	50.00	50.00	No billing received
8.	Non-MSA Counties	76818	50.00	50.00	No billing received
1.	Chattanooga, TN	76825*	128.44	No billing received	No billing received
2.	Clarksville, TN	76825*	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	76825*	No billing received	No billing received	No billing received
4.	Knoxville, TN	76825*	No billing received	No billing received	No billing received
5.	Memphis, TN	76825*	No billing received	No billing received	No billing received
6.	Nashville - Davidson, TN	76825*	No billing received	No billing received	No billing received
.	Jackson, TN	76825*	No billing received	No billing received	No billing received
8.	Non-MSA Counties	76815*	No billing received	No billing received	No billing received

*76825 - This service is rendered on an infrequent basis.

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OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	76855	38.56	No billing received	No billing received
2.	Clarksville, TN	76855	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	76855	38.56	No billing received	No billing received
4.	Knoxville, TN	76855	38.56	No billing received	No billing received
5.	Memphis, TN	76855	No billing received	No billing received	No billing received
6.	Nashville - Davidson, TN	76855	38.41	No billing received	No billing received
7.	Jackson, TN	76855	No billing received	No billing received	No billing received
8.	Non-MSA Counties	76855	No billing received	No billing received	No billing received
1.	Chattanooga, TN	90000	23.00	22.25	No billing received
2.	Clarksville, TN	90000	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90000	23.00	No billing received	No billing received
4.	Knoxville, TN	90000	23.00	No billing received	No billing received
5.	Memphis, TN	90000	23.00	23.00	No billing received
6.	Nashville - Davidson, TN	90000	23.00	23.00	No billing received
7.	Jackson, TN	90000	10.00	23.00	No billing received
8.	Non-MSA Counties	90000	22.65	21.69	No billing received

*Codes 90000-90280 replaced codes 59800 and 59810 in 1992. Codes 90000-90280 were replaced in 1993.

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90010	30.00	No billing received	No billing received
2.	Clarksville, TN	90010	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90010	29.37	30.00	No billing received
4.	Knoxville, TN	90010	30.00	30.00	No billing received
5.	Memphis, TN	90010	30.00	30.00	No billing received
6.	Nashville - Davidson, TN	90010	29.50	29.33	No billing received
7.	Jackson, TN	90010	30.00	30.00	No billing received
8.	Non-MSA Counties	90010	30.00	29.87	No billing received
1.	Chattanooga, TN	90015	40.00	40.00	No billing received
2.	Clarksville, TN	90015	35.00	37.50	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90015	39.95	40.00	No billing received
4.	Knoxville, TN	90015	40.00	36.50	No billing received
5.	Memphis, TN	90015	40.00	39.94	No billing received
6.	Nashville - Davidson, TN	90015	39.48	38.00	No billing received
7.	Jackson, TN	90015	39.00	40.00	40.00
8.	Non-MSA Counties	90015	40.00	39.38	No billing received

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OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90017	49.83	50.00	No billing received
2.	Clarksville, TN	90017	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90017	49.16	47.50	No billing received
4.	Knoxville, TN	90017	50.00	46.50	No billing received
5.	Memphis, TN	90017	47.14	50.00	No billing received
6.	Nashville - Davidson, TN	90017	48.25	49.60	No billing received
7.	Jackson, TN	90017	47.00	No billing received	50.00
8.	Non-MSA Counties	90017	43.05	49.71	No billing received
1.	Chattanooga, TN	90015	59.93	No billing received	No billing received
2.	Clarksville, TN	90015	53.40	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90015	59.60	60.00	No billing received
4.	Knoxville, TN	90015	59.86	59.11	No billing received
5.	Memphis, TN	90015	55.45	60.00	No billing received
6.	Nashville - Davidson, TN	90015	59.29	60.00	No billing received
7.	Jackson, TN	90015	54.34	No billing received	No billing received
8.	Non-MSA Counties	90015	58.06	60.00	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90030	9.00	9.00	No billing received
2.	Clarksville, TN	90030	9.00	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90030	8.95	9.00	9.00
4.	Knoxville, TN	90030	9.00	9.00	No billing received
5.	Memphis, TN	90030	No billing received	9.00	No billing received
6.	Nashville - Davidson, TN	90030	8.97	9.00	No billing received
7.	Jackson, TN	90030	9.00	9.00	No billing received
8.	Non-MSA Counties	90030	9.00	8.75	No billing received
1.	Chattanooga, TN	90040	18.00	18.00	No billing received
2.	Clarksville, TN	90040	18.00	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90040	17.91	18.00	No billing received
4.	Knoxville, TN	90040	17.93	18.00	No billing received
5.	Memphis, TN	90040	18.00	18.00	No billing received
6.	Nashville - Davidson, TN	90040	17.88	17.76	No billing received
7.	Jackson, TN	90040	17.47	18.00	18.00
8.	Non-MSA Counties	90040	17.77	17.82	No billing received

Attachment 4.19-B

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90050	22.00	20.88	No billing received
2.	Clarksville, TN	90050	22.00	22.00	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90050	21.40	22.00	22.00
4.	Knoxville, TN	90050	21.92	22.00	No billing received
5.	Memphis, TN	90050	22.00	22.00	No billing received
6.	Nashville - Davidson, TN	90050	21.88	22.00	No billing received
7.	Jackson, TN	90050	21.85	21.94	22.00
8.	Non-MSA Counties	90050	21.97	21.71	No billing received
1.	Chattanooga, TN	90060	27.00	26.50	No billing received
2.	Clarksville, TN	90060	26.90	27.00	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90060	26.89	27.00	27.00
4.	Knoxville, TN	90060	26.94	27.00	No billing received
5.	Memphis, TN	90060	26.68	27.00	No billing received
6.	Nashville - Davidson, TN	90060	26.79	26.73	No billing received
7.	Jackson, TN	90060	26.86	26.85	27.00
8.	Non-MSA Counties	90060	26.91	26.61	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90070	32.00	32.00	No billing received
2.	Clarksville, TN	90070	30.00	32.00	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90070	32.00	32.00	No billing received
4.	Knoxville, TN	90070	32.00	32.00	No billing received
5.	Memphis, TN	90070	32.00	32.00	No billing received
6.	Nashville - Davidson, TN	90070	31.61	32.00	No billing received
7.	Jackson, TN	90070	32.00	32.00	40.00
8.	Non-MSA Counties	90070	31.28	31.95	No billing received
1.	Chattanooga, TN	90080	37.00	37.00	No billing received
2.	Clarksville, TN	90080	37.00	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90080	37.00	37.00	No billing received
4.	Knoxville, TN	90080	37.00	37.00	No billing received
5.	Memphis, TN	90080	37.00	37.00	No billing received
6.	Nashville - Davidson, TN	90080	36.90	37.00	No billing received
7.	Jackson, TN	90080	37.00	No billing received	No billing received
8.	Non-MSA Counties	90080	36.84	37.00	No billing received

Attachment 4.19-B

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90130	No billing received	No billing received	No billing received
2.	Clarksville, TN	90130	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90130	No billing received	No billing received	No billing received
4.	Knoxville, TN	90130	No billing received	No billing received	No billing received
5.	Memphis, TN	90130	No billing received	No billing received	No billing received
6.	Nashville - Davidson, TN	90130	7.32	No billing received	No billing received
7.	Jackson, TN	90130	No billing received	No billing received	No billing received
8.	Non-MSA Counties	90130	No billing received	No billing received	No billing received
1.	Chattanooga, TN	90200	27.71	No billing received	No billing received
2.	Clarksville, TN	90200	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90200	27.71	No billing received	No billing received
4.	Knoxville, TN	90200	27.46	No billing received	No billing received
5.	Memphis, TN	90200	27.71	No billing received	No billing received
6.	Nashville - Davidson, TN	90200	27.71	27.71	No billing received
7.	Jackson, TN	90200	27.71	No billing received	No billing received
8.	Non-MSA Counties	90200	27.68	27.71	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90215	44.88	No billing received	No billing received
2.	Clarksville, TN	90215	No billing received	No billing received	No billing received
3.	Johnson City-Kingsport, Bristol, TN	90215	44.88	50.24	No billing received
4.	Knoxville, TN	90215	44.54	No billing received	No billing received
5.	Memphis, TN	90215	44.55	No billing received	No billing received
6.	Nashville-Davidson, TN	90215	44.79	37.27	No billing received
7.	Jackson, TN	90215	48.39	No billing received	No billing received
8.	Non-MSA Counties	90215	42.32	46.14	No billing received
1.	Chattanooga, TN	90220	43.92	60.18	No billing received
2.	Clarksville, TN	90220	43.73	No billing received	No billing received
3.	Johnson City-Kingsport, Bristol, TN	90220	56.52	57.12	No billing received
4.	Knoxville, TN	90220	54.94	55.76	No billing received
5.	Memphis, TN	90220	56.68	54.60	No billing received
6.	Nashville-Davison, TN	90220	53.86	58.70	No billing received
7.	Jackson, TN	90220	42.50	60.03	No billing received
8.	Non-MSA Counties	90220	51.67	52.74	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90225	No billing received	No billing received	No billing received
2.	Clarksville, TN	90225	No billing received	30.00	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90225	No billing received	30.00	No billing received
4.	Knoxville, TN	90225	No billing received	29.95	No billing received
5.	Memphis, TN	90225	30.00	30.00	No billing received
6.	Nashville - Davidson, TN	90225	30.00	30.00	No billing received
7.	Jackson, TN	90225	30.00	30.00	No billing received
8.	Non-MSA Counties	90225	30.00	29.97	No billing received
1.	Chattanooga, TN	90240	9.67	14.79	No billing received
2.	Clarksville, TN	90240	No billing received	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90240	11.66	10.45	No billing received
4.	Knoxville, TN	90240	13.46	No billing received	No billing received
5.	Memphis, TN	90240	13.51	No billing received	No billing received
6.	Nashville - Davidson, TN	90240	13.51	No billing received	No billing received
7.	Jackson, TN	90240	14.79	No billing received	No billing received
8.	Non-MSA Counties	90240	12.86	13.26	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90250	13.52	14.36	No billing received
2.	Clarksville, TN	90250	13.20	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90250	13.01	12.42	No billing received
4.	Knoxville, TN	90250	13.29	13.77	No billing received
5.	Memphis, TN	90250	13.50	14.79	No billing received
6.	Nashville - Davidson, TN	90250	12.94	14.60	No billing received
7.	Jackson, TN	90250	14.79	No billing received	No billing received
8.	Non-MSA Counties	90250	13.55	14.25	No billing received
1.	Chattanooga, TN	90260	13.42	18.61	No billing received
2.	Clarksville, TN	90260	17.01	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90260	18.02	17.57	No billing received
4.	Knoxville, TN	90260	18.02	18.61	No billing received
5.	Memphis, TN	90260	18.02	18.61	No billing received
6.	Nashville - Davidson, TN	90260	17.90	17.97	No billing received
7.	Jackson, TN	90260	17.06	18.61	40.00
8.	Non-MSA Counties	90260	16.53	18.10	No billing received

OBSTETRICAL SERVICES

AVERAGE PAYMENT PER SPECIALTY
for July 1, 1991 - June 30, 1992

MSA		PROCEDURE	Obstetrician	Family Practitioner	Certified Nurse Midwife
1.	Chattanooga, TN	90270	No billing received	No billing received	No billing received
2.	Clarksville, TN	90270	25.67	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90270	25.67	26.35	No billing received
4.	Knoxville, TN	90270	No billing received	No billing received	No billing received
5.	Memphis, TN	90270	25.67	28.18	No billing received
6.	Nashville - Davidson, TN	90270	23.80	30.39	No billing received
7.	Jackson, TN	90270	No biling received	No billing received	No billing received
8.	Non-MSA Counties	90270	20.96	25.55	No billing received
1.	Chattanooga, TN	90280	No billing received	No billing received	No billing received
2.	Clarksville, TN	90280	21.68	No billing received	No billing received
3.	Johnson City - Kingsport, Bristol, TN	90280	21.68	No billing received	No billing received
4.	Knoxville, TN	90280	21.68	20.00	No billing received
5.	Memphis, TN	90280	21.68	No billing received	No billing received
6.	Nashville - Davidson, TN	90280	21.67	34.76	No billing received
7.	Jackson, TN	90280	21.25	No billing received	No billing received
8.	Non-MSA Counties	90280	21.68	33.80	No billing received

D1143098

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

5.a. Physician services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For procedures which are covered by Medicare, physician service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For procedures which are not covered by Medicare, physician service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1010047

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

5.b. Physician services furnished in the office, the patient's home, a hospital, a skilled facility, or elsewhere.

1. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for other provider-preventable conditions (PPCs).

2. No reduction in payment for Other Provider-Preventable Conditions (OPPCs) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

3. Reductions in provider payment may be limited to the extent that the following apply:

   a. The identified provider-preventable conditions would otherwise result in an increase in payment.

   b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions in the following manner:

      Physician services providers are paid based on a fee-for-service payment methodology. It is the responsibility of the physician providing services to identify and report any OPPC and not seek payment from Medicaid for services provided to treat an OPPC.

   c. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

4. Physician records will be retroactively reviewed by the State or its agent. If any services are identified that are due to a PPC, then the State or its agent will initiate recoupment for the identified overpayment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

5.b. Physician services furnished in the office, the patient's home, a hospital, a skilled facility, or elsewhere, continued.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Sections 4.19A and 4.19B.

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

On and after the effective date below, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NEs) as defined by the National Coverage Determination (NCD). The Never Events (NEs) as defined in the NCD include Inpatient Hospitals, Outpatient Hospitals, Clinics, Ambulatory Surgical Centers (ASCs), and practitioners, and these providers will be required to report NEs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

5.c. **Physician Services 42 CFR 447.405 Amount of Minimum Payment**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

___The rates reflect all Medicare site of service and locality adjustments.

_X_ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

____The rates reflect all Medicare geographic/locality adjustments.

_X_ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: Tennessee has only 1 geographical/locality adjustment

Method of Payment

X The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

___The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ___monthly ___quarterly

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Primary Care Services Affected by this Payment Methodology

___This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

X The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

Non Reimbursable Codes by ALL TennCare Managed Care Organizations (MCO): 99288, 99339, 99358, 99359, 99363, 99364, 99366, 99367, 99368, 99374, 99377, 99379, 99444, 99450, 99455, 99456, 99485, 99486, 99487, 99488, 99489

Non Reimbursable Codes Specific to TennCare MCO:
AmeriGroup - 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99340, 99380

UnitedHealthcare - 99360

Volunteer State Health Plan - 99340, 99380, 99441, 99442, 99443

Medicare/Medicaid Crossover Payments made by TennCare:
For the dates of service and specified E&M codes described in this SPA, TennCare will reimburse Medicare/Medicaid crossover claims at 100% of the Medicare designated Coinsurance and Deductible amounts.

X The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

All TennCare Managed Care Organizations (MCO) - 99224 (1/1/11), 99225 (1/1/11), 99226 (1/1/11), 99495 (1/1/13), 99496 (1/1/13)

Codes Specific by MCO:
AmeriGroup - 99441 (9/1/10), 99442 (9/1/10), 99443 (9/1/10)

Medicare/Medicaid Crossover Payments made by TennCare:

For the dates of service and specified E&M codes described in this SPA, TennCare will reimburse Medicare/Medicaid crossover claims at 100% of the Medicare designated Coinsurance and Deductible amounts.

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Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

___Medicare Physician Fee Schedule rate

_X_State regional maximum administration fee set by the Vaccines for Children program

___Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

___The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.

_X_A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: AmeriGroup – $13.70 UnitedHealthcare -$13.12 to $15.93 depending on Contracted Fee Schedule; Volunteer State Health Plan - $10.25.

___Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

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Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at http://www.tn.gov/tenncare/providers.shtml.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at http://www.tn.gov/tenncare/providers.shtml.

Attachment 4.19B

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Rev. 88-11

6.a. ~~15.~~ Podiatrists Services - Payment is not to exceed the lesser of: the billed amount, a percentage of the usual and customary charge of each individual podiatrist or a percentage of the 75th percentile of the statewide prevailing charges for the base year used to calculate the profile.

Reimbursement shall be made at the rate in effect when service is provided.

6.b. ~~16.~~ Optometrists Services - payment is not to exceed the lesser of: the billed amount, a percentage of the usual and customary charge of each individual optometrist or a percentage of the 75th percentile of the statewide prevailing charges for the base year used to calculate the profile.

Reimbursement shall be made at the rate in effect when service is provided.

88-5 3/3/88 5/3/88 11/1/88

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

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.

6.c. Chiropractors' Services

Payment for chiropractors' services is made at 75 percent of the rates established by Medicare.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

6.a.1. Podiatrists Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For procedures which are covered by Medicare, podiatrists service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For procedures which are not covered by Medicare, podiatrists service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1040060

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

6.b.1. Optometrists Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For procedures which are covered by Medicare, optometrists service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For procedures which are not covered by Medicare, optometrists service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1050060

Attachment 4.19B

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

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.

6d. Other practitioners' services

1. Physician Assistant

a. For services rendered at an SNF or ICF, reimbursement for a physician assistant service may not exceed 60 percent of the allowed amount for the comparable service rendered by a licensed physician.

b. Physician assistant services performed in a hospital (other than as an assistant-at-surgery) may not exceed 60 percent of the allowed amount for comparable services rendered by a licensed physician.

c. When a physician assistant performs services as an assistant-at-surgery, reimbursement may not exceed 60 percent of the allowed amount for a licensed physician assistant-at-surgery.

2. Certified Registered Nurse Anesthetist

a. Payment for services provided with medical direction will be the lesser of billed charges or forty-four percent (44%) of what would have been paid to a physician for similar services.

b. Payment for services provided without medical direction will be the lesser of billed charges or eighty percent (80%) of what would have been paid to a physician for similar services.

D1059166

TN No. 89-17 DATE/RECEIPT 8/15/89
SUPERSEDES DATE/APPROVED 8/29/89
TN No. NEW DATE/EFFECTIVE 7/1/89

AT-89-17
Effective 7/1/89

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

6.d.3. Other Practitioners Services – Physician Assistant.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For physician assistant services which are covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For physician assistant services which are not covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1060060

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

6.d.4. Certified Registered Nurse Anesthetist.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For procedures which are covered by Medicare, certified registered nurse anesthetist service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 80% of the physician's reimbursement for the procedure.

For procedures which are not covered by Medicare, certified registered nurse anesthetist service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 80% of an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1070060

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
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7. Home Health Services

a. Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, and Speech Evaluation services provided by a Home Health Agency

Reimbursement shall be the lesser of:

(1) Billed charges, or
(2) Reasonable costs according to Medicare principles of reimbursement and limits, or
(3) The median statewide cost per visit for each home health care service as determined each July 1. Each provider's most recent cost report on file as of April 1 of each year will be included in the determination of the median. Costs per visit will be trended from the midpoint of the state's fiscal year using the forecasted percent increase in the home health agency market basket as published in the federal register.

Interim payments are based on previous year's costs and year-end cost settlements are made for each agency. In no event shall reimbursement exceed the per visit limits established by Medicare.

b. Medical Supplies

(1) When provided by a Home Health Agency, reimbursement shall be the lesser of:

(a) billed charges; or
(b) 100% of the 75th percentile of Medicare prevailing charges in effect as of June 30, 1988; or
(c) where there are no Medicare prevailing charges, an amount established under a State fee schedule in effect June 30, 1988; or
(d) The lowest bid price for the equipment, device, appliance or supply resulting from advertisements requesting bids from qualified vendors to furnish these items.

All payments for medical supplies are deemed payment in full and are excluded from the cost reports.

(2) When provided by other providers, reimbursement shall be the lesser of:

(a) billed charges; or
(b) 100% of the 75th percentile of Medicare prevailing charges; or

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

7. Home Health Services (continued)

(c) where there are no Medicare prevailing charges, an amount established under a State fee schedule in effect June 30, 1988; or
(d) The lowest bid price for the equipment, device, appliance or supply resulting from advertisements requesting bids from qualified vendors to furnish these items.

All payments for medical supplies are deemed payment in full and are excluded from the cost reports.

(3) When a specific item is determined by the Department to be essential to the health of the recipient, and the absence of the item could reasonably be expected to result in a significant deterioration in the recipient's health status, the price limitations described above may be waived if the Department determines the price limitation significantly and adversely affects accessibility of the item.

c. Purchased Durable Medical Equipment, Prosthetic Devices, Orthotic Appliances

(1) When provided by a Home Health Agency or Medical Vendor, reimbursement shall be the lesser of:

(a) billed charges; or
(b) 100% of the 75th percentile of Medicare prevailing charges in effect as of June 30, 1988; or
(c) Where there are no Medicare prevailing charges, an amount established under a state fee schedule in effect June 30, 1988; or
(d) The lowest bid price for the equipment, device, appliance or supply resulting from advertisements requesting bids from qualified vendors to furnish these items.

(2) Necessary repairs, maintenance and replacement of expendable parts of purchased equipment shall be reimbursed at 80% of billed charges.

All payments for durable medical equipment, prosthetic devices, and orthotic appliances are deemed payment in full and are excluded from the cost reports.

d. Rental Equipment

In the case of rental equipment, Medicaid reimburses a monthly rental payment which is ten (10) percent of the Medicaid allowable

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

Home Health Services (continued)

purchase fee, except that the following rental only items are reimbursed at the lesser of: billed charges; or the Medicare prevailing monthly rental charge in effect as of June 30, 1988.

(1) Oxygen concentrator
(2) Oxygen system (gas setup)
(3) Oxygen system (gas portable)
(4) Oxygen system (liquid stationary)
(5) Oxygen system (liquid portable)
(6) Ventilator portable (home-use)

All payments for rental equipment are deemed payment in full and are excluded from cost settlement.

D3078293

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

7.1. Home Health Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

Home health care services providers per visit reimbursement will be:

(1)	Skilled nursing care	$69.31
(2)	Physical therapy	$79.14
(3)	Speech therapy	$88.47
(4)	Occupational therapy	$89.13
(5)	Home health aide	$31.82

D1130060

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

7.1.c. Home Health Services – Medical Supplies, Equipment, and Appliances.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For medical supplies, equipment and appliances which are covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For medical supplies, equipment and appliances which are not covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1060067

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

8. Private Duty Nursing Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For private duty nursing services which are covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For private duty nursing services which are not covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1050067

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

9. Clinic Services (continued)

(2) Ambulatory Surgical Centers

Payment is for facility services and shall be the lesser of:

(a) billed charges, or

(b) an amount based upon Medicare principles as described in 42 CFR 416.120(c).

In no event shall reimbursement exceed the rates determined pursuant to 42 CFR 416.120(c) and in effect July 1, 1988 or the upper limits pursuant to 42 CFR 447.321.

(3) Methadone clinic services

Methadone clinic providers effective June 2, 2020 will be reimbursed the lesser of:

(a) billed charges, or

(b) reasonable allowable cost computed according to Medicare principles of reimbursement.

(c) Payments will not exceed the upper limits pursuant to 42 CFR 447.321.

Attachment 4.19B

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
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9. Clinic Services (continued)

(2) Ambulatory Surgical Centers

Payment is for facility services and shall be the lesser of:

(a) billed charges, or

(b) an amount based upon Medicare principles as described in 42 CFR 416.120(c).

In no event shall reimbursement exceed the rates determined pursuant to 42 CFR 416.120(c) and in effect July 1, 1988 or the upper limits pursuant to 42 CFR 447.321.

(3) Community Mental Retardation Clinics

Payment for covered services shall be a prospective fee equal to the lesser of billed charges or a maximum amount established by Medicaid for the type service provided.

Payments will not exceed the upper limits pursuant to 42 CFR 447.321.

D3032258

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

9.b.1. Community Clinics – Community Health Clinics, Community Health Agencies, Community Services Clinics, Ambulatory Surgical Centers.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For community clinic services which are covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For community clinic services which are not covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1080060

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

9.b.2. Clinic Services – Ambulatory Surgical Centers.

1. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for other provider-preventable conditions (PPCs).

2. No reduction in payment for Other Provider-Preventable Conditions (OPPCs) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

3. Reductions in provider payment may be limited to the extent that the following apply:

   a. The identified provider-preventable conditions would otherwise result in an increase in payment.

   b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions in the following manner:

      Ambulatory Surgical Centers/Clinics are paid based on a fee-for-service payment methodology. It is the responsibility of the Ambulatory Surgical Center (ASC) or clinic providing services to identify and report any OPPC and not seek payment from Medicaid for services provided to treat an OPPC.

   c. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

4. Ambulatory Surgical Center/Clinic records will be retroactively reviewed by the State or its agent. If any services are identified that are due to a PPC, then the State or its agent will initiate recoupment for the identified overpayment.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

9.b.2. Clinic Services – Ambulatory Surgical Centers, continued.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Sections 4.19A and 4.19B.

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

On and after the effective date below, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NEs) as defined by the National Coverage Determination (NCD). The Never Events (NEs) as defined in the NCD include Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASCs), and practitioners, and these providers will be required to report NEs.

Attachment 4.19B

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

10. Dental Services

Dental service payment is not to exceed the lesser of:

a. billed amount,
b. 85% of the usual and customary charges accumulated by each individual dentist, or
c. 85% of the 75th percentile of the range of weighted customary charges by dentists in the State (Dental profile) for the 1984 calendar year.

Dental service reimbursement shall not exceed the amount in effect June 30, 1988.

D3088293

AT-88-11
Effective 7/1/88

TN No. 88-11 SUPERCEDES TN No. 84-1
DATE/RECEIPT 6/30/88
DATE/APPROVED 12/5/88
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

10.a. Dental Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

Dental service payment shall not exceed the following:

Medicaid Code	Dental Procedure Description	Price
D0120	Periodic oral exam	$17.00
D0150	Oral exam by specialist	17.00
D0210	Intraoral complete (Includes bitewings)	50.00
D0220	Intraoral-periapical-1st film	8.00
D0230	Intraoral-periapical-each additional film	6.00
D0272	Bitewings-2 films	17.00
D0273	Bitewings-3 films	18.00
D0274	Bitewings-4 films	23.00
D0330	Panoramic film (excludes bitewings)	42.00
D1110	Prophylaxis - adult	30.00
D1120	Prophylaxis - child	25.00
D1203	Topical application fluoride	17.00
D1351	Sealant - per tooth	15.00
D1510	Space Maintainer-fixed-unilateral	94.00
D1515	Space Maintainer-fixed-bilateral	165.00
D1550	Recementation of space maintainer	15.00
D2110	Amalgam-one surface-primary	27.00
D2120	Amalgam-two surface- primary	35.00
D2130	Amalgam-three surface-primary	49.00
D2131	Amalgam-4 + surface-primary	49.00
D2140	Amalgam-one surface-permanent	30.00
D2150	Amalgam two surface (connecting) permanent	38.00
D2160	Amalgam three surface (connecting) permanent	48.00
D2161	Amalgam four surface (connecting) permanent	53.00
D2330	Resin-one surface-anterior	35.00

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

10.a. Dental Services (continued)

D2331	Resin-two surface-anterior (connecting)	45.00
D2332	Resin-three surface-anterior (connecting)	55.00
D2710	Crown - resin	91.00
D2750	Crown - porcelain- fused to metal	350.00
D2920	Recement Crown	18.00
D2930	Prefab stainless steel crown-primary	70.00
D2931	Prefab stainless steel crown-permanent	75.00
D2950	Crown build-up, including pins	66.00
D2951	Pin retention-per tooth in addition to restoration	18.00
D2952	Cast post and core in addition to crown	81.00
D2954	Prefab post and core in addition to crown	54.00
D2980	Crown repair	40.00
D2999	*Unspecified restorative procedure, by report*	35.00
D3110	Pulp cap-direct (excluding final restorations)	20.00
D3220	Therapeutic pulpotomy	38.00
D3310	One canal (excluding final restoration)	221.00
D3320	Two canals (excluding final restoration)	263.00
D3330	Three canals (excluding final restoration)	332.00
D3350	Apexification	44.00
D3410	Apicoectomy	88.00
D3430	Retrograde filling	17.00
D3999	Unspecified endodontic procedure, by report	p/a
D4210	Gingivectomy - per quadrant	83.00
D4341	Periodontal scaling and root planning - quadrant	50.00
D5110	Complete upper denture	325.00
D5120	Complete lower denture	325.00
D5211	Upper Partial - acrylic base (incl. convential clasps/rests)	300.00
D5212	Lower Partial - acrylic base (incl. convential clasps/rests)	300.00
D5213	Upper Partial - predominantly base cast base	450.00
D5214	Lower Partial - predominantly base cast base	450.00
D5281	Removable unilateral partial denture - one piece	333.00
D5610	Repair acrylic saddle or base	55.00
D5620	Repair cast framework	88.00
D5630	Repair or replace broken clasp	34.00
D5640	Repair broken teeth- per tooth	39.00
D5650	Add tooth to existing partial denture	77.00
D5660	Add clasp to existing partial denture	48.00
D5730	Reline upper complete (chairside)	54.00
D5731	Reline lower complete (chairside)	54.00
D5740	Reline upper partial (chairside)	54.00
D5741	Reline lower part (chairside)	54.00

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10.a. Dental Services (continued)

D5750	Reline upper complete (lab)	68.00
D5751	Reline lower complete (lab)	68.00
D5760	Reline upper partial (lab)	68.00
D5761	Reline lower partial (lab)	68.00
D5899	Unspecified removable prosthodontics proc. by report	p/a
D5956	Maxillary obturator	400.00
D6920	Connector Bar	15.00
D7110	Routine extraction-single	35.00
D7120	Routine extraction-each additional	33.00
D7130	Root removal-exposed roots	30.00
D7210	Surgical removal- erupted tooth	70.00
D7220	Removal of impacted tooth-soft tissue	70.00
D7230	Removal of impacted tooth-partial bony	100.00
D7240	Remove impacted tooth-completely bony	120.00
D7250	Surgical removal of residual tooth roots(cutting proc)	55.00
D7270	Tooth reimplantation &/or stabilization (in accident)	110.00
D7280	Surgical exposure of impacted tooth for orthodontics	125.00
D7281	Surgical exposure of impacted tooth to aid eruption	28.00
D7286	Biopsy of oral tissue-soft	39.00
D7310	Alveoplasty in conj w/extractions- per quadrant	36.00
D7320	Alveoplasty not in conj w/extractions- per quadrant	55.00
D7430	Excision of benign tumor =< 1.25 cm	43.00
D7450	Removal of odontogenic cyst or tumor =<1.25 cm	56.00
D7470	Removal of exostosis maxilla or mandible - per quadrant	74.00
D7510	Incision and drainage of abcess-intraoral soft tissue	38.00
D7960	Frenulectomy (frenectomy or frenotomy)-separate proc	83.00
D7999	Unspecified oral surgery, by report	P/a
D2114	Initial exam/banding	800.00
D2116	Orthodontic adjustments	80.00
D9110	Palliative (emergency) treatment of dental pain - minor	25.00
D9240	Intravenous sedation	100.00
D9230	Analgesia	20.00
D9630	Office premedication	15.00
Y2111	Nonconforming procedures	p/a
Y2115	Supernumery services	p/a

D1120060

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12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12.a. Prescribed Drugs

(1) Payments for covered outpatient drugs shall generally be defined according to the type of pharmacy being reimbursed. Payments made in accordance with 42 CFR § 447.512 (i.e., basing ingredient cost of a drug on Actual Acquisition Cost) and 42 CFR § 447.502 (describing the professional dispensing fee) are as follows:

(a) Ambulatory Pharmacies

i. Ambulatory pharmacies are licensed by the Tennessee Board of Pharmacy and include retail pharmacies and any other entities that dispense outpatient drugs directly to enrollees.

ii. Payments to ambulatory pharmacies for covered outpatient legend and over-the-counter drugs will be made at—

a. The Federal Upper Limit (FUL), plus a professional dispensing fee; or

b. The Average Actual Acquisition Cost (AAAC), if there is no FUL or if the AAAC is lower than the FUL, plus a professional dispensing fee; or

c. The National Average Drug Acquisition Cost (NADAC), if there is no AAAC or if the NADAC is lower than the AAAC, plus a professional dispensing fee; or

d. The Wholesale Acquisition Cost (WAC) minus three percent for brand-name drugs or WAC minus six percent for generic drugs, if there is no AAAC or NADAC, plus a professional dispensing fee; or

e. The Usual and Customary charge to the public, if it is lower than the four preceding options.

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iii. The professional dispensing fees for ambulatory pharmacies will be tiered based on annual prescription volume. The tiers are—

- $11.98 for pharmacies with a prescription volume of less than 65,000 claims per year;
- $8.37 for pharmacies with a prescription volume of 65,000 or more claims per year; and
- $11.98 for pharmacies that opened within one year of the State's cost-of-dispensing survey.

(b) 340B Covered Entities

i. 340B covered entities are providers that participate in the 340B Drug Pricing Program and that fill enrollees' prescriptions with drugs purchased at prices authorized under Section 340B of the Public Health Service Act.

ii. Payments to 340B covered entities will be made at—

a. The 340B ceiling price, plus a professional dispensing fee; or

b. The 340B covered entities' Acquisition Cost, if lower than the 340B ceiling price, plus a professional dispensing fee.

iii. Payments to 340B covered entities for drugs obtained outside the 340B Drug Pricing Program will be made according to the same methodology applicable to ambulatory pharmacies.

iv. Drugs acquired through the 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered.

v. The professional dispensing fee for 340B covered entities will be based on the type of claim being submitted. For claims submitted as 340B claims, the professional dispensing fee is set at $15.40. For claims submitted as non-340B claims, the professional dispensing fee is set at $11.98.

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(c) Pharmacies that purchase drugs through the Federal Supply Schedule will be reimbursed no more than the Actual Acquisition Cost of the drug, plus a professional dispensing fee that is tiered in the same manner as the dispensing fee for ambulatory pharmacies.

(d) Pharmacies that purchase drugs at Nominal Price (outside of the 340B Drug Pricing Program or the Federal Supply Schedule) will be reimbursed no more than the Actual Acquisition Cost of the drug, plus a professional dispensing fee that is tiered in the same manner as the dispensing fee for ambulatory pharmacies.

(e) Reimbursement for compounded prescriptions will consist of an ingredient cost based on the same methodology applied to ambulatory pharmacies, and a professional dispensing fee that is tiered according to the pharmacist's reported level of effort. The tiers are—

- Level 1 (0-15 minutes) – $11.98 for pharmacies with a prescription volume of less than 65,000 claims per year, and $10.00 for pharmacies with a prescription volume of 65,000 or more claims per year
- Level 2 (16-30 minutes) – $15.00
- Level 3 (31 or more minutes) – $25.00

(2) Drug payments to which the requirements of 42 CFR § 447.512 do not apply shall adhere to the following methodology:

(a) Long-Term Care Pharmacies

i. Long-term care pharmacies are licensed by the Tennessee Board of Pharmacy and are closed-door pharmacies (i.e., are not open to the general public). Long-term care pharmacies dispense drugs only to long-term care facilities and/or to other group facilities.

ii. Payments to long-term care pharmacies for covered outpatient legend and over-the-counter drugs will be made at—

a. The Federal Upper Limit (FUL), plus a professional dispensing fee; or

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b. The Average Actual Acquisition Cost (AAAC), if there is no FUL or if the AAAC is lower than the FUL, plus a professional dispensing fee; or

c. The National Average Drug Acquisition Cost (NADAC), if there is no AAAC or if the NADAC is lower than the AAAC, plus a professional dispensing fee; or

d. The Wholesale Acquisition Cost (WAC) minus three percent for brand-name drugs or WAC minus six percent for generic drugs, if there is no AAAC or NADAC, plus a professional dispensing fee.

iii. The professional dispensing fee for long-term care pharmacies is set at $11.98.

iv. Long-term care pharmacies must dispense medications in a manner that enables the return to stock of unused portions, with a credit to TennCare for those portions.

(b) Specialty Pharmacies / Specialty Drugs

i. Specialty pharmacies are licensed by the Tennessee Board of Pharmacy. Specialty pharmacies primarily dispense specialty drugs that are not dispensed by ambulatory pharmacies and distribute these drugs through the mail. Specialty drugs do not appear on the National Average Drug Acquisition Cost (NADAC) list maintained by CMS. Reimbursement in this category is based on the classification of the drug being dispensed rather than the type of pharmacy dispensing the drug.

ii. Payments to specialty pharmacies for specialty drugs will be made at—

a. The Average Actual Acquisition Cost (AAAC), plus a professional dispensing fee; or

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b. The Wholesale Acquisition Cost (WAC) minus three percent for brand-name drugs or WAC minus six percent for generic drugs, if there is no AAAC, plus a professional dispensing fee.

iii. The professional dispensing fee for non-specialty drugs dispensed by in-state specialty pharmacies is set at $11.98. The professional dispensing fee for specialty drugs (regardless of which type of pharmacy dispenses them) is set at $45.94.

(c) Blood Clotting Factors and Other Blood Products

i. For entities other than specialty pharmacies, hemophilia treatment centers (HTCs), and hemophilia-related centers of excellence that are 340B covered entities, payment for blood clotting factors and other blood products will be made at the Average Actual Acquisition Cost, plus a professional dispensing fee of $172.69.

ii. For specialty pharmacies, HTCs, and hemophilia-related centers of excellence that are 340B covered entities, payment for blood clotting factors and other blood products will combine the ingredient cost methodology applicable to 340B covered entities, defined previously in 12.a.(1)(b), with a professional dispensing fee of $172.69.

(d) Out-of-State Pharmacies

i. For out-of-state pharmacies that have a prescription volume of less than 65,000 claims per year and that are located in border areas closer to TennCare members than Tennessee pharmacies are, the professional dispensing fee for drugs other than specialty drugs and blood clotting factors is set at $11.98.

ii. For all other out-of-state pharmacies serving TennCare members (including out-of-state specialty pharmacies), the professional dispensing fee for drugs other than specialty drugs and blood clotting factors is set at $8.37.

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iii. The professional dispensing fee for specialty drugs dispensed by out-of-state pharmacies is set at $45.94.

iv. The professional dispensing fee for blood clotting factors and other blood products dispensed by out-of-state pharmacies is set at $172.69.

(e) Pharmacies that Fail to Respond to a Mandatory Pharmacy Reimbursement Survey

i. The State conducts periodic surveys of pharmacy providers participating in the TennCare program. These surveys address such subjects as Average Actual Acquisition Cost, the costs associated with professional dispensing of prescription drugs, and other topics related to pharmacy reimbursement, and are necessary to establish reimbursement rates in accordance with federal requirements (see 42 CFR § 447.518). Since the results of these surveys are used to calculate pharmacy reimbursement rates, participation by all TennCare pharmacy providers is mandatory.

ii. For pharmacies that fail to provide a useable response to two mandatory surveys, the professional dispensing fee is set at the State's lowest calculated rate of $8.37.

iii. For pharmacies that fail to provide a useable response to three mandatory surveys, the professional dispensing fee is set at $5.00.

iv. A pharmacy that receives a lower dispensing fee because of failure to provide a useable response to a mandatory survey may resume receiving its usual dispensing fee by submitting a useable response to the next mandatory survey.

(f) Investigational drugs are not a covered service.

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

12.b. Prescribed Drugs.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

(1) Payment for legend drugs authorized under the program may be made through a contract with one or more pharmacy benefits vendors or directly to participating pharmacies. Payment shall include:

(a) Payment for the cost of legend drugs will be in conformity with 42 CFR 447.331 and will be the lesser of:

(i) Estimated acquisition cost, which is defined as the average wholesale price (AWP), as published in a nationally recognized compendium approved by the State, minus 13% plus a dispensing fee, or

(ii) Maximum allowable cost (MAC), which is defined as the published upper limit of reimbursement which in most cases is the same or lower than that described in 42 CFR 447.332, plus a dispensing fee. (Excluded from aggregate comparison will be any unit doses packaged by the pharmaceutical manufacturer and used in an institutional setting. To assure that payment for the multiple source drugs described in 42 CFR 447.332 does not exceed the aggregate expenditures, an annual report will be prepared to demonstrate compliance.); or

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12.b. Prescribed Drugs (continued)

(iii) Tennessee maximum allowable cost (TMAC) plus a dispensing fee, or

(iv) Provider's usual and customary charge, which is defined as the charge to the non-Medicaid patient and which is confirmed via post-payment audits of the provider's prescription files and usual and customary fee schedules by the State Comptroller's Office, or

(v) If the drug is purchased via contract prices eligible to an inpatient facility and/or non-profit institution, actual invoice price plus a dispensing fee.

(b) The dispensing fee for legend drugs is established at $2.50 for each prescription dispensed by pharmacy providers who comply with State-approved preferred provider credentialing requirements or special exemption requirements and $2.00 for each prescription dispensed by other pharmacy providers, except for approved long-term care unit dose vendors for whom the dispensing fee is established at $6.00 for unit dose prescriptions.

D1100060

Attachment 4.19B

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Rev 4 mpl 55-11

12d. 9. Eyeglasses - Payment not to exceed the lower of usual and customary charges or the following:

(a) Qualified providers will be reimbursed forty dollars for the examination and refraction of a patient.

(b) Qualified providers will be reimbursed twenty-two dollars for a pair of single vision (glass or plastic) lenses.

(c) Qualified providers will be reimbursed twenty-four dollars and eighty cents for a pair of bifocal or multifocal vision (glass or plastic lenses).

(d) Qualified providers will be reimbursed the actual acquisition cost for special lenses, which have been prior approved by Medicaid.

(e) Qualified providers will be reimbursed eighteen dollars for a pair of standard frames.

(f) In addition to the above, the provider will receive a dispensing fee of twenty-one dollars for dispensing a pair of eyeglasses.

AT-87-38
Effective 11/20/87

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

12.d.1. Eyeglasses.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

Vision services will be reimbursed on a fee schedule set at 85% of the Medicare rate allowable for the service.

D1010067

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

13.c. Preventive services

Payment for administration of COVID-19 immunizations is made at 100 percent of the rates established by Medicare. These rates recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine. These rates will also be geographically adjusted. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers for COVID-19 vaccinations.

Attachment 4.19B

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

13.d. Rehabilitative Services

For rehabilitative services which are restricted to mental health services provided by eligible providers, on a differential rate established for the category of service provided.

The designated categories of service are outpatient brief, outpatient individual, outpatient group, medical doctor, evaluation-short, evaluation-extended and evaluation-long.

The State assures that it will comply with the upper limit of payment assurance required by 42 CFR 447.321. The rates are cost based and individualized by category of service. Cost records that establish the prospective rate will be maintained and audited annually. The rates will be adjusted in subsequent years to reflect new cost information. The State will not reimburse more than cost.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

13.d. Rehabilitative Services – continued

C. Buprenorphine Enhanced Supportive Medication-Assisted Recovery and Treatment (BE-SMART)

Buprenorphine enhanced supportive medication-assisted recovery and treatment (BE-SMART) services are covered for members as medically necessary in accordance with Attachments 3.1-A and 3.1-B to provide a continuum of care within community-based settings.

Providers of individual services within the BE-SMART program are reimbursed individually based on the individual service provided. Effective January 1, 2021, providers will be reimbursed the lesser of billed charges or 85% of the Medicare rate for the service.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

13.d. Rehabilitative Services

A. Rehabilitative Services by Community Mental Health Centers

For rehabilitative services which are restricted to mental health services provided by eligible providers, on a differential rate established for the category of service provided.

The designated categories of service are outpatient brief, outpatient individual, outpatient group, day program short, day program long, and medical doctor.

The state assures that it will comply with the upper limit of payment assurance required by 42 CFR 447.321. The rates, which are specific to each provider, are cost based and individualized by category of service. For the first three years, the annual rates for each provider's categories of service will be based on reported aggregate costs for the previous fiscal year. The rate will then be adjusted by the Consumer Price Index for outpatient hospital related services. After three years of experience, actual rather than reported costs will be used in establishing rates. This methodology is consistent with Medicare principles for determining payment under the lower of cost or charges provision.

B. Rehabilitative Services by Community Mental Health Clinics

Payment for covered services shall be a prospective fee equal to the lesser of billed charges or a maximum amount established by Medicaid for the type service provided.

Payments will not exceed the upper limits pursuant to 42 CFR 447.325.

D1152154

Attachment 4.19B

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

17. Nurse-midwife services

a. Medicaid reimbursement to nurse-midwives for covered services will be the lesser of:

1. Billed amount; or

2. 90% of the maximum amount paid to physicians statewide for similar maternity and newborn services.

b. Reimbursement is not available for physician supervision of the nurse midwife when performing uncomplicated maternity and uncomplicated newborn services. In no instance, will Medicaid duplicate reimbursement to a nurse midwife and a physician for delivery of uncomplicated maternity and uncomplicated newborn services to the same recipient during the same maternity and newborn cycle.

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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

17.a. Nurse-Midwife Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For procedures which are covered by Medicare, nurse-midwife service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For procedures which are not covered by Medicare, nurse-midwife service payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1090060

Attachment 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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18. Hospice Care (in accordance with section 1905(o) of the Act).

Reimbursement for hospice services shall be the lesser of billed charges or 100% of a prospectively determined rate per covered day which is based upon the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Rates shall be determined for each of four levels of care as set out in 42 CFR 418.302 and adjusted for inflation as set out in 42 CFR 418.309. Medicaid reimbursement to a hospice in a cap period is limited to a cap amount as set out in 42 CFR 418.309.

D3040136(3)

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SUPERSEDES DATE/APPROVED 11/27/90
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EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

18.a. Hospice Care (in accordance with section 1905(o) of the Act).

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

Reimbursement for hospice services shall be the lesser of billed charges or 100% of a prospectively determined rate per covered day which is based upon the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Rates shall be determined for each of four levels of care as set out in 42 CFR 418.302 and adjusted for inflation as set out in 42 CFR 418.309. Medicaid reimbursement to a hospice in a cap period is limited to a cap amount as set out in 42 CFR 418.309. Additional reimbursement shall be made for a hospice beneficiary who is residing in a nursing facility or intermediate care facility for the mentally retarded for room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services, in accordance with Section 1902(a)(13)(B) of the Social Security Act.

D1020061

Attachment 4.19B
(Program A)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Program (A) - Pregnant Women

Reimbursement will be on a prospective basis. Cost records that establish the prospective rates will be maintained and audited annually. Rates will be adjusted in subsequent years to reflect new cost information. The state will not reimburse more than cost.

The description of services provided and reimbursement rates are as follows:

Description	Fee
Initial month, prenatal	$50.00
Subsequent month, prenatal	$25.00
Home visit, prenatal	$42.00

Maximum reimbursement per month for any combination of services cannot exceed $92.00 per month.

D3119191

AT-89-24
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Attachment 4.19-B
(Program B)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

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19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Program (B) - Infants and Children Under Age 2

Reimbursement will be on a prospective basis. Cost records that establish the prospective rates will be maintained and audited annually. Rates will be adjusted in subsequent years to reflect new cost information. The state will not reimburse more than cost.

The description of services provided and reimbursement rates are as follows:

Description	Fee
Initial month, child	$50.00
Subsequent month, child	$25.00
Home visit, child	$42.00

Maximum reimbursement per month for any combination of services cannot exceed $92.00 per month.

D2049200

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Attachment 4.19B
(Program C)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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RATES - OTHER TYPES OF CARE

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Program (C) - Mental Health

Reimbursement will be on a prospective basis. Cost records that establish the prospective rate will be maintained and audited annually. The rate will be adjusted in subsequent years to reflect new cost information. The State will not reimburse more than cost. The maximum reimbursement per month per individual served will be a rate not to exceed the 75th percentile of rates established for all participating providers.

D1040248

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

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19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Program (D) - Children In State Custody or At Risk of State Custody

Reimbursement will be on a prospective basis. An interim rate of $155 per recipient per month will be established, with year end cost settlement being made to reflect the actual reasonable costs of providing the service. The State will not reimburse more than cost.

D3022069

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or sectin 1915(g) of the Act).

Program (E) - Children's Special Services (CSS) Targeted Case Management

Reimbursement will be made based upon an interim rate of $36.73 per initial visit and $25.95 per other contact with year-end cost settlement being made to reflect the actual reasonable costs of providing the service. The interim rate calculations include factors such as the type of provider and case manager, the type of service(s) provided and the time spent for each encounter. Subsequent interim rate adjustments will include these same factors and will be made on a statewide aggregate basis. Year-end cost settlements will be provider specific and will occur shortly after the cost reporting year is completed. It is anticipated that all cost reports will be based upon state fiscal year (July-June). The State will not reimburse more than cost.

D1153012

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

21.a. Certified Pediatric or Family Nurse Practitioners Services.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

For certified pediatric or family nurse practitioners services which are covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) 85% of the Medicare rate for the procedure.

For certified pediatric or family nurse practitioners services which are not covered by Medicare, payment is not to exceed the lesser of:

(1) the billed amount; or
(2) an amount established under a state fee schedule. Aggregate payment will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

D1070067

Attachment 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

for eff 7/1/87

~~14.~~ 22. Respiratory Care Services

Provided through a Home Health Agency: Payment is based on reasonable cost as determined under standards and principles applicable to Title XVIII.

Attachment 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

23.a. Transportation

1. Ambulance Services

(a) Emergency land ambulance - payment shall be 67.5% of the federal Medicare program's allowable charge for participating providers.

(b) Non-Emergency land ambulance payment shall be 67.5% of the federal Medicare program's allowable charge for participating providers.

(c) Emergency air ambulance - payment shall be the lesser of:

(1) Billed charges for the services,
(2) 100% of the 75th percentile of the Medicare prevailing charges for the services, or
(3) A maximum of $100 for the base rate, $3.00 per loaded mile and $15 for oxygen.

Attachment 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

The maximum payment per ambulance transport shall not exceed $573.00. When emergency air ambulance services are provided and it is determined that emergency land ambulance services would have sufficed, payment shall be the lesser of the land ambulance rate or the air ambulance rate for the transport.

2. Volunteer Transportation Services

Volunteer transportation services will be reimbursed the rate per mile as specified in the Comprehensive Travel Regulations of the State of Tennessee.

3. Commercial Transportation Services

Commercial providers will be reimbursed:

a. An individually negotiated rate, or

b. The prevailing commercial rate. The prevailing commercial rate will serve as the upper limit for commercial providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

23.b. Transportation.

This methodology will be used only during a designated emergency period. It will be discontinued at the time that the designated emergency period is determined to have ended.

1. Ambulance Services

(a) Emergency land ambulance – payment shall be lesser of:

(1) Billed charges for the services,
(2) 85% of Medicare allowable, or
(3) A maximum of $65 for the basic life support base rate, $100 for the advanced life support base rate, $1.10 per loaded mile outside the county and $10 for oxygen.

(b) Non-Emergency land ambulance payment shall be the lesser of:

(1) Billed charges for the services,
(2) 85% of Medicare allowable, or
(3) A maximum of $65 one-way or $130 round-trip for the non-emergency base rate, $1.10 per loaded mile outside the county and $10 for oxygen.

(c) Emergency air ambulance – payment shall be the lesser of:

(1) Billed charges for the services,
(2) 100% of the 75th percentile of the Medicare prevailing charges for the services, or
(3) A maximum of $100 for the base rate, $3.00 per loaded mile and $15 for oxygen.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

23.b. Transportation (continued)

The maximum payment per ambulance transport shall not exceed $573.00. When emergency air ambulance services are provided and it is determined that emergency land ambulance services would have sufficed, payment shall be the lesser of the land ambulance rate or the air ambulance rate for the transport.

2. Volunteer Transportation Services

Volunteer transportation services will be reimbursed the rate per mile as specified in the Comprehensive Travel Regulations of the State of Tennessee.

3. Commercial Transportation Services

Commercial providers will be reimbursed:

a. An individually negotiated rate, or

b. The prevailing commercial rate. The prevailing commercial rate will serve as the upper limit for commercial providers.

D1070061

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item 24. Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual		Medicare-Medicaid/QMB Individual		Medicare-QMB Individual	
Part A Deductible	X	limited to State plan rates*	X	limited to State plan rates*	X	limited to State plan rates*
	___	full amount	___	full amount	___	full amount
Part A Coinsurance	X	limited to State plan rates*	X	limited to State plan rates*	X	limited to State plan rates*
	___	full amount	___	full amount	___	full amount
Part B Deductible	X	limited to State plan rates*	X	limited to State plan rates*	X	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Coinsurance	X	limited to State plan rates*	X	limited to State plan rates*	X	limited to State plan rates*
	X	full amount	X	full amount	X	full amount

*For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) 25.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

25. Other Medicare covered services not covered under the plan are reimbursed at the full amount or at the Medicaid allowable amount.

Attachment 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

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26. Licensed or Otherwise State – Approved Freestanding Birth Centers

Reimbursement is based on rates negotiated between the Managed Care Organizations (MCOs) and the freestanding birth centers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Tennessee

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

27. **1905(a)(29) Medication-Assisted Treatment (MAT)**

The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder (OUD) will be the same methodology described in Attachment 4.19-B, Item 12.a (Prescribed Drugs).

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item 1 of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item 1 of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item 1 of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP Deductibles	SP	Coinsurance
	Part B	NR Deductibles	NR	Coinsurance
Other Medicaid Recipients	Part A	SP Deductibles	SP	Coinsurance
	Part B	NR Deductibles	NR	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP Deductibles	SP	Coinsurance
	Part B	NR Deductibles	NR	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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1. Other Medicare covered services not covered under the State plan are reimbursed at the full amount or at the Medicaid allowable amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19A.

_X_ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Sections 4.19A and 4.19B.

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider-preventable conditions would otherwise result in an increase in payment.

ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

iii. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.