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

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

2. Fee schedule.

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

B. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by ~~HCFA~~CMS. DMAS shall adjust ~~HCFA's~~ CMS' CFs by an additional factor so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. DMAS shall calculate a separate additional factor for (1) Obstetrical/Gynecological procedures (defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual) and for (2) all other procedures set through the RBRVS process combined. DMAS may revise the additional ~~factor~~ factors when ~~HCFA~~ CMS updates its RVUs or CFs so that no change in expenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by ~~HCFA~~CMS. The calculation of the additional ~~factor~~ factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule. The determination of the ~~"~~additional ~~factor"~~ factors required above shall be accomplished by means of the following calculation:

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

2. The estimated amount of DMAS expenditures, if DMAS were not to calculate new fees based on the new ~~HCFA~~ CMS RVUs and CFs, is equal to the sum, across all relevant procedure codes, of the existing DMAS fee multiplied by the number of

occurrences of the procedures code in DMAS patient claims in the period of time used in subdivision 1 of this subsection.

3. The relevant ~~"~~additional factor~~"~~ is equal to the ratio of the expenditure estimate (based on DMAS fees in subdivision 2 of this subsection) to the expenditure estimate based on unmodified ~~HCFA~~ CMS values in subdivision 1 of this subsection.

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

D. Fees shall not vary by geographic locality.

E. The RBRVS-based fees shall be phased in over three years. During the first 12 months of implementation, fees shall be based ~~&frac13~~ 1/3; on RBRVS-based fees and ~~&frac23~~;2/3 on previously existing fees. During the second 12 months of implementation, fees shall be based ~~&frac23~~; 2/3 on RBRVS-based fees and ~~&frac13~~;1/3 on previously existing fees. Thereafter, fees shall be based entirely on RBRVS-based fees.

F. (Reserved for ER Physician Rate Increase)

G. Effective for dates of service on or after September 1, 2004, fees for Obstetrical/Gynecological procedures (defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual) shall be increased by 34 percent relative to the fees in effect on July 1, 2004. This 34 percent increase shall be a one-time increase, but shall be included in subsequent calculations of the relevant "additional factor" described in Section B above.