REIMBURSEMENT FOR SERVICES PROVIDED BY PHYSICIANS, LIMITED LICENSE PRACTITIONERS, AND NON-PHYSICIAN PRACTITIONERS

I. A. Summary of the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology

All services provided by physicians, limited license practitioners, and non-physician practitioners will be reimbursed according to a statewide fee schedule based on a Resource-Based Relative Value Scale (RBRVS). This includes services provided by:

Physicians and Limited License Practitioners
- doctors of medicine,
- osteopaths,
- physician or primary care group practices,
- optometrists,
- podiatrists,
- dentists who are oral surgeons,
- chiropractors, and
- health service providers in psychology.

Non-Physician Practitioners
- audiologists,
- speech therapists,
- licensed psychologists
- independent laboratory or radiology providers,
- dentists who are not oral surgeons,
- social workers certified through the American Academy of Certified Social Workers,
- advance practice nurses,
- physician assistants, and
- mental health professionals.

The components of the RBRVS methodology used to develop the fee schedule include the Medicare-based Relative Value Units (RVUs), the Geographic Practice Index (GPCI), and a conversion factor. RVUs for each procedure were developed by HCFA to represent the resource-use associated with individual procedures. These RVUs were adjusted using the Medicare Urban locality GPCI to reflect work, practice, and malpractice costs in Indiana. The following GPCI values were multiplied by the Medicare-based RVUs to obtain Indiana-specific RVUs for each procedure:

- Work: 0.980
- Practice Expense: 0.905
- Malpractice: 0.516

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The conversion factor was developed using Indiana Medicaid claims data from fiscal year 1992 and specific policy assumptions relative to the Indiana Medicaid program. To determine the payment rate for each procedure under the RBRVS fee schedule, the Indiana-specific RVU for each procedure is multiplied by the conversion factor according to the following calculation:

\[
\text{Payment Amount} = (\text{Indiana RVU} \times \text{Indiana Medicaid Conversion Factor})
\]

The Indiana Medicaid conversion factor is $28.61.

I. B. Summary of exceptions to the RBRVS reimbursement methodology

1. For procedures where no Medicare RVU exists, the RBRVS fee schedule amount was established using RVUs from other state Medicaid programs or developed specifically for the Indiana Medicaid program. For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement is based on the fee value of the national Medicare clinical laboratory fee schedule.

2. The Medicaid office developed RBRVS fee schedule amounts for certain maternity and primary care procedures to give special consideration to the importance of maternity and primary care services in the Indiana Medicaid program. The RBRVS fee schedule amounts for the following HCPCS codes were not developed using the RBRVS methodology:

   - 59000 - 59130,
   - 59136 - 59320,
   - 59350 - 59426,
   - 59500 - 59851, and
   - 99211.

3. The RBRVS fee schedule amounts for anesthesiology procedures were developed using the total base and time units for each procedure multiplied by the Indiana Medicaid conversion factor for anesthesiology, $13.88.

4. The RBRVS fee schedule amounts for services of dentists in calendar year 1994 were developed based on fiscal year 1992 charges and the percentage difference between physician and LLP submitted charges for fiscal year 1992 and RBRVS fee schedule amounts. The Medicaid agency may set reimbursement for specific dental procedures using a different methodology in order to preserve access to the service. Effective 8/1/95, fees for covered dental services are priced at the levels in effect at the end of calendar year 1994, increased by a percentage (20%) determined by the Medicaid agency. In order to address a crisis, the agency complied with the above Plan to use a different methodology in order to preserve access to dental services by setting reimbursement rates for most dental procedures equal to 100% of the 75th percentile of the rates reported by the American Dental Association for the East North Central Region (ADA-ENC), effective May 1, 1998. The ADA-ENC-based rates may be adjusted annually for inflation, using the Consumer Price Index – Urban, Dental (CPI-UD).
I. B. Summary of exceptions to the RBRVS reimbursement methodology (continued)

4. Continued from previous page:
Rates paid to providers in accordance with the methods described in Attachment 4.19-B for dental services are subject to a five percent (5%) rate reduction for services provided on or after April 1, 2010. The 5% rate reduction will remain in effect through June 30, 2011. These rates are published at the State's website, www.indianamedicaid.com.

5. For telemedicine services provided through interactive television, a facility fee for the spoke site (the location where the patient is physically present) is reimbursed at the lesser of the provider's billed charge or the maximum allowance established by the Office of Medicaid Policy and Planning. The reimbursement rate is paid for one unit per encounter, and the maximum allowance is a state-wide rate based on Medicare's 2005 allowance for the spoke site service. OMPP has the option to revise the maximum allowance upon review to ensure it is reasonable and sufficient to promote use of this service.

If a health care provider’s presence at the spoke site is determined to be medically necessary by the provider at the hub site, separate reimbursement is available for the appropriate evaluation and management code for the service provided.

The maximum allowance for reimbursement to the hub site (the location of the practitioner providing the consultation services) is based on specific Evaluation and Management (E&M) and End Stage Renal Disease codes and paid as if a traditional encounter were performed.
II. Application of reimbursement methodology for services provided by physicians and limited license practitioners (LLPs)

1. Reimbursement for services provided by physicians and limited license practitioners (LLPs), except for services described in subdivisions two (2) through six (6) below, will be equal to the lower of:
   - the provider’s submitted charges for the procedure, or
   - the established RBRVS fee schedule allowance for the procedure.

2. Services provided by assistant surgeons will be reimbursed at twenty percent (20%) of the RBRVS fee schedule amount for the procedure and surgeons at sixty-two and one-half percent (62.5%) of the RBRVS fee schedule amount for the procedure.

3. Reimbursement for all services is subject to the global surgery policy as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services. The global surgery policy will not apply to the following codes:
   - 59410 - vaginal delivery, including post-partum care, and
   - 59515 - caesarean delivery, including post-partum care.

4. Reimbursement for services provided by physicians and LLPs is subject to the policy for supplies and services incident to other procedures as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services.

5. Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections.

6. Reimbursement for services provided by physicians and LLPs is subject to the site-of-service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician’s office will be paid at eighty percent (80%) of the RBRVS fee schedule amount for the procedure. These procedures are identified using the site-of-service indicator on the Medicare fee schedule database.

7. Payments for services to an out-of-state-provider will be negotiated on a case-by-case basis to obtain the lowest possible rate, not to exceed 100% of the provider’s reasonable and customary charges, and may differ from the reimbursement methodology or amounts set out in the Indiana Administrative Code when required because the services are not available in-state or are necessary due to unique medical circumstances requiring care that is available only from a limited number of qualified providers.

III. Application of the RBRVS reimbursement methodology for services provided by non-physician practitioners (NPPs)

1. Reimbursement for services provided by non-physician practitioners (NPPs), except services described in subdivisions 2 and 3 below, will be equal to the lower of:
   - the submitted charge for the procedure, or
   - the established RBRVS fee schedule amount for the procedure.
2. Outpatient mental health services provided by:

   social workers who are either certified through the American Academy of Certified Social Workers (ACSW) or holding masters of social work (MSW) degrees, psychologists with basic certificates, and licensed psychologists in a physician-directed outpatient mental health facility in accordance with 401 IAC 1-6-13 and 401 IAC 1-7-20 will be reimbursed at seventy-five percent (75%) of the RBRVS fee schedule amount for that procedure.

3. Services provided by independently practicing respiratory therapists (42 CFR 440.60), physical therapists’ assistants (42 CFR 440.110) and advance practice nurses (42 CFR 440.166) will be reimbursed at seventy-five percent (75%) of the RBRVS fee schedule amount for that procedure. State developed fee schedule rates are the same for both public and private providers of these services. The fee schedule and any annual/periodic adjustments to the fee schedule are published.

IV. Additional provisions related to the RBRVS reimbursement methodology

1. The RBRVS fee schedule will be reviewed annually and adjusted as necessary, taking into account the Medicare fee schedule proposed by the CMS to take effect January 1 of the following calendar year.

V. Faculty Physician Access to Care Adjustments for Services Provided by Medical School Faculty Physicians

1. Beginning June 2, 2003, the office will make adjustments to payments, as necessary, for services provided by faculty physicians to Medicaid recipients in order to maintain adequate access to primary and specialty faculty physician services as required by 42 USC 1396(a)(30) and 42 CFR 447.204, and to compensate faculty physicians for their additional costs incurred in providing faculty physician services to Medicaid patients. The office will make adjustments to payments as follows:

   a. Subject to 42 CFR 447.10 and b. below, adjustments to payments for faculty physician services will be made quarterly by the office in an amount not to exceed the lesser of billed charges or an amount equal to the difference between:
      i. the amounts paid for services rendered to Medicaid recipients pursuant to the RBRVs fee schedule; and
      ii. the amounts that are the usual charges as defined in c. below, for the same services.
b. The adjustments to payments for faculty physician services are subject to the following:
   
i. In the event that sufficient funds are not available to provide the full amount of the state share for the adjustments, payments of the adjustments to the faculty physicians will be reduced proportionately; and

   ii. Beginning January 1, 2005, the amounts of the faculty physicians’ payments will be subject to the office’s performance standards. The office may adjust the faculty physicians’ payments based upon the office’s review and the faculty physicians’ satisfaction of the office’s performance standards, as stated in Section 2. below, in order to ensure adequate access to care for Medicaid recipients.

c. “Usual charges” are defined as follows:
   
i. For services rendered for the time period of June 2, 2003 through December 31, 2003, usual charges for faculty physician services to Medicaid patients will be an amount determined as follows:
      
      A. the average (as measured during the 2003 calendar year) of the following amounts: amounts billed to cash paying patients; the amounts billed to patients covered by indemnity insurers with which the provider has no contractual arrangement; and any fee-for-service rates the faculty physicians contractually agree to accept from any payor, including any discounted fee-for-service rates negotiated with managed care plans.

      B. amounts not included in the average are charges for services provided to uninsured patients free of charge or at a substantially reduced rate, capitated payments, rates offered under hybrid fee-for-service arrangements whereby more than 10% of the individual’s or entity’s maximum potential compensation could be paid in the form of a bonus and/or withhold payment; and fees set by Medicare, state health care programs, and other federal health care programs.
ii. For calendar years beginning after December 31, 2003, usual charges will be an amount equal to the amount of the immediately preceding calendar year’s usual charges, increased by an amount that is equal to the applicable Medicare Sustainable Growth Factor (“SGF”), as calculated pursuant to the formula at 42 USCS 1395w-4(f)(2).

2. For calendar years beginning after January 1, 2004, the office will annually review faculty physician reports and documentation regarding the office’s annual performance standards in order to measure and evaluate whether the faculty physicians have achieved them. The results of the annual review will be applied to the quarterly payments for the following calendar year as described in the example on Attachment 4.19-B, Page 1c.3, Section VI. of this state plan.
VI. Faculty Physician Access to Care Adjustments for Services Provided by Medical School Faculty Physicians: Payment Example

To illustrate the payment methodology proposed by TN 03-014 for Faculty Physician Access to Care adjustments, the following example is displayed within this plan.

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Assumptions: Faculty physicians are employed by or are members of the Indiana University Medical Group-Primary Care or the Indiana University Medical Group-Specialty Care. Faculty Physicians have established and the office has approved performance standards #1 through #5 for hypothetical calendar year 00. The results of the annual review for calendar year 00 have been determined. Thus, the payments of the adjustments for hypothetical calendar year 01 will be as illustrated below:

Faculty Physicians’ are scored on each of the five performance standards. These scores are then expressed as percentages to indicate the Performance Level Achieved. The Performance Level Achieved is multiplied by the Weight of the Score to arrive at the Percentage Earned. The Percentages Earned of all of the performance standards are added together to arrive at the percentage that the faculty physicians will be paid of the total amount determined under V.1.a. of Attachment 4.19-B, Pages 1c and 1c.1 of this plan.

<table>
<thead>
<tr>
<th>Performance Standards</th>
<th>Performance Level Achieved</th>
<th>Weight of Score</th>
<th>% Earned</th>
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**TOTAL** 75%

* Assuming the amounts of the adjustments equal $100,000 for each of the four quarters of calendar year 01, payments to the faculty physicians would equal $75,000 (75% of $100,000) for each of the next four quarters.

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VII. Payment Adjustment To Physicians Who Specialize In Primary and Preventive Care Services

Effective July 1, 2007 the office will make a one-time payment adjustment to physicians that provide primary and preventative care services. The physicians subject to this adjustment include family practitioners, general practitioners, obstetricians/gynecologists, general internists, and general pediatricians. For purposes of this adjustment, the office has identified seventy-five (75) procedures considered to be primary and preventative care services, including evaluation and management procedures, certain delivery procedures, and preventative medicine procedures. The procedure code ranges are as follows: 59409-59410, 59514-59515, 59612, 59614, 59620, 59622, 99201-99205, 99211-99215, 99217-99223, 99231-99236, 99238-99239, 99241-99245, 99251-99255, 99281-99285, 99291-99296, 99298-99299, 99318, 99354-99357, 99381-99387, and 99391-99397.

The practice settings include services provided in the office, urgent care facility, inpatient hospital, outpatient hospital, emergency department, and ambulatory surgical center.

In determining the amount of the payment adjustment under this provision, the office shall examine historical utilization from physicians. The payment adjustment will be computed as follows:

1) A percentage increase will be applied to the current Medicaid fee for the seventy-five (75) primary and preventative care services procedures, including evaluation and management procedures, certain delivery procedures, and preventative medicine procedures. Medicaid payments under this state plan amendment for FFY 2008 shall be based on historic claims paid between January 1, 2006 and March 31, 2007 ("Period 1"), and April 1, 2007 and August 31, 2007 ("Period 2"). The percentage payment increase for Period 1 claims shall be 23.68%, and the percentage for Period 2 claims shall be 37.52%. The resulting fee shall be limited to the Medicare fee in effect during 2007 for Indiana providers.

2) Historic claims for Periods 1 and 2 will be re-priced based on the service fee percentage increase identified above. Claims with third party payments or spend down amounts will be excluded.

3) The payment adjustment amount is equal to the difference between the original payment amount and the re-priced payment amount determined in step 2, and will be paid in a one-time lump sum payment to all five physician specialty practitioners, both governmental and private providers, providing these services. No payment adjustments will be made for services rendered after FFY 2008.
Reimbursement for Nursing Services Performed in a School Setting

Reimbursement for Individualized Education Program (IEP) nursing services for eligible individuals will be paid on a fee-for-service basis. The rate will be established by the Medicaid agency based on actual costs submitted by Home Health Agencies (HHA) for services provided by Registered Nurses (RN). HHA nursing services are similar in nature to the IEP nursing services, thus the available HHA costs are used to determine the IEP nursing rates. The rate is a statewide rate, computed by dividing salaries, benefits, and overhead costs for RN staff by the number of RN hours as reported on Home Health Agency cost reports. The result of this calculation is an hourly RN cost for each HHA. The RN hourly cost for each HHA is then arrayed from highest to lowest, and the IEP nursing rate is the median of the HHA RN hourly cost amounts. The established rate will be reviewed annually and adjusted as necessary. Payment will be based on the lower of the provider’s submitted charge or the established rate. The unit of service will be 15 minutes.

The state-developed fee schedule rate is available only to Indiana Medicaid enrolled local educational agencies (LEAs) which provide school-based, IEP-related nursing services. The agency’s fee schedule rate was set as of January 1, 2010 and is effective for services provided on or after that date. All rates are published on the State’s website at: www.indianamedicaid.com.
Pharmacy Services

1. Legend Drugs - Payment is based on the lowest of:
   
   (A) For brand name drugs, AWP as of the date dispensed – 16% plus a $4.90 dispensing fee
   
   (B) For generic drugs, AWP as of the date dispensed – 20% + a $4.90 dispensing fee;
   
   (C) Applicable Federal Upper Limit (“FUL”) as established by CMS, as of the date dispensed, plus a $4.90 dispensing fee;
   
   (D) Applicable State Maximum Allowable Cost (“State MAC”) as of the date dispensed, plus a $4.90 dispensing fee;
   
   (E) The provider’s usual and customary charge for the drug to the general public (which is the charge to be submitted to Indiana Medicaid), as of the date dispensed;

   minus a recipient copayment amount, where applicable, as set out in Attachment 4.18-A.

   The upper limit for a multiple source legend drug for which a specific FUL or State MAC has been established does not apply when a physician specifies the medical necessity of the brand name product by handwriting the words "Brand Medically Necessary" on the form, and obtains prior authorization for that specification.

2. Non-Legend (OTC) Drugs - Payment is based on the lower of:

   (A) One hundred fifty percent (150%) of:

       The State maximum allowable cost for the OTC drug, as set out in the Medicaid Pharmacy Provider Manual and amendments thereto, in the quantity dispensed, as of the date dispensed, minus any applicable copayment amount; or

   (B) The provider’s usual and customary charge for the OTC drug to the general public (which is the charge to be submitted to Indiana Medicaid), as of the date dispensed;

   minus any applicable drug copayment amount.

   OTC insulin is reimbursed at the estimated acquisition cost (EAC) of the drug, plus any applicable Medicaid dispensing fee. EAC is:

       (1) for brand name drugs, eighty-four percent (84%); or

       (2) for generic drugs, eighty percent (80%) of the average wholesale price for each National Drug Code according to the Medicaid contractor’s drug database file.
State Maximum Allowable Costs for Legend Drugs—State MACs for legend drugs are developed and maintained as follows: The State MAC is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual acquisition cost will be developed by using pharmacy invoices and other information that the Office determines is necessary. The purpose of the multiplier is to ensure that the applicable State MAC rate is sufficient to allow reasonable access by providers to the drug at or below the established State MAC rate. The Office of Medicaid Policy and Planning (OMPP) will review State MAC rates on an ongoing basis, and adjust the rates as necessary to reflect prevailing market conditions and ensure reasonable access by providers to drugs at or below the applicable State MAC rate. Pharmacies and providers that are enrolled in the Indiana Health Coverage Programs (IHCP) are required, as a condition of participation, to make available and submit to the OMPP or its designee, acquisition cost information, product availability information, or other information deemed necessary by the OMPP for the efficient operation of the pharmacy benefit within the IHCP, in the format requested by the OMPP or its designee. This information will be used in the development and ongoing maintenance of the State MACs.

Blood Factor Product Administered During an Inpatient Stay

Blood factor products used during an inpatient hospital stay shall be paid based on the state maximum allowable cost (state MAC) rate for the blood factor products. Hospital providers shall submit claims for reimbursement in accordance with the instructions set forth in the Indiana health coverage programs manual or update bulletins.

Medical and Surgical Supplies

Reimbursement for medical supplies is equal to the lower of the following:
(1) The provider’s submitted charges, not to exceed the provider’s usual and customary charges.
(2) The Medicaid allowable fee schedule amount, which is the base statewide fee schedule amount equal to the lower of the Medicaid fee schedule amount in effect during SFY 2001 or the amount determined as follows:

(1) the average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available; then
(2) the Indiana Medicare fee schedule amount adjusted by a multiplier of no less than eight-tenths (.8), if available. If this amount is not available; then
(3) the weighted median of providers’ usual and customary charges adjusted by a multiplier of no less than eight-tenths (.8), if available. If this amount is not available; then
(4) the Medicaid fee schedule amount in effect during the state fiscal year 2001, if available. If this amount is not available; then
(5) the average Indiana Medicaid payment amount per item during state fiscal year 2001.

The office may review the statewide fee schedule and adjust it as necessary using the Medicare fee schedule, the providers’ usual and customary charges, and the providers’ acquisition cost information subject to (1) through (5) above.

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