



Healthy Indiana Plan Reimbursement Manual

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Section 1: Rules

Overview

The Healthy Indiana Plan (HIP) is a program sponsored by the State of Indiana that provides a more affordable healthcare choice to thousands of otherwise uninsured individuals throughout Indiana. HIP provides health insurance for uninsured adult Hoosiers between the ages of 19 and 64 whose incomes are up to 200% of the federal poverty level (FPL), and who are not otherwise eligible for Medicaid. Unlike many other government-sponsored programs, parents and childless adults can participate. Eligible participants must be uninsured for at least six months and cannot have access to employer-sponsored health insurance. Participants are required to make monthly contributions toward coverage.

This section provides the Indiana Administrative Code (IAC) HIP reimbursement rules, Enhanced Services Plan (ESP) rules, and annual and lifetime benefit limits.

HIP Reimbursement Rule

405 IAC 9-2-23 “Plan reimbursement rate” defined

Authority: IC 12-15-44-19
Affected: IC 12-15-44

Sec. 23. “Plan reimbursement rate” means the amount of reimbursement insurers pay to providers participating in the plan. This amount shall:

- (1) not be less than the federal Medicare reimbursement rate for the service provided; or
- (2) at a rate of one hundred thirty-percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

(Office of the Secretary of Family and Social Services: 405 IAC 9-2-23)

HIP Enhanced Services Plan (ESP) Reimbursement Rule

405 IAC 9-6-2 Enhanced services plan; fee for service delivery system; reimbursement rates

Authority: IC 12-15-44-19
Affected: IC 12-15-44; IC 27-8-10.1

Sec. 2. (a) The enhanced services shall be administered through a fee for service delivery system administered by the association.

(b) The association shall provide medical management services. A member shall participate in the medical management services provided.

(c) Members shall have access to providers who are enrolled as Medicaid providers.

(d) Reimbursement to providers rendering services to ESP members shall be at Medicare fee schedule rates except that pharmacy services shall be reimbursed at Medicaid rates.

(e) Providers rendering services to ESP members are subject to all provisions contained in the Medicaid provider agreement except as amended by this article. *(Office of the Secretary of Family and Social Services: 405 IAC 9-6-2)*

Annual and Lifetime Benefit Limits

405 IAC 9-7-2 Covered benefits and services; coverage limits

- b) The following per member reimbursement limitations apply:

- (1) An annual individual maximum reimbursement limitation of three hundred thousand dollars (\$300,000).
- (2) A lifetime individual maximum reimbursement limitation of one million dollars (\$1,000,000).

(c) Members that may exceed the maximum coverage limitations established in this section shall be:

- (1) notified by the office or its designee; and
 - (2) referred for potential eligibility in other programs;
- when the member exceeds **one hundred thousand dollars (\$100,000) in paid claims in a year**, two hundred thousand dollars (\$200,000) in **paid claims in a year** or **and** nine hundred thousand dollars (\$900,000) **in paid**

claims in a lifetime. (Office of the Secretary of Family and Social Services: 405 IAC 9-7-2)

HIP Covered Benefits

405 IAC 9-7-2 Covered benefits and services; coverage limits

Authority: IC 12-15-44.2
Affected: IC 12-15-44.2

Sec. 2. (a) The following services are covered under the plan according to the coverage criteria, limitations, and procedures specified in this article and in manuals, bulletins, or other documentation published by the insurers, association, and the office:

- (1) Mental health care services.
- (2) Inpatient hospital services.
- (3) Skilled nursing facility services, subject to a sixty (60) day maximum per coverage term.
- (4) Pharmacy services.
- (5) Emergency services.
- (6) Physician office services.
- (7) Diagnostic services, including pregnancy testing.
- (8) Outpatient services, including covered therapy services as defined in section 4.
- (9) Comprehensive disease management.
- (10) Home health services, including case management.
- (11) Urgent care center services.
- (12) Preventive care services.
- (13) Family planning services as with the exception of over-the-counter contraceptives.
- (14) Hospice services.
- (15) Substance abuse services.
- (16) Services provided at a federally qualified health center (FQHC) or rural health center (RHC)
- (17) Durable medical equipment.
- (18) Lead screening services and hearing aids for individuals nineteen (19) years of age or twenty (20) years of age.
- (19) Any additional services the insurers or association offers, as approved by the office and in accordance with the terms of the insurers' policy or the association's plan.

Section 2: Reimbursement Procedures

Overview

This section describes the procedures for reimbursing providers contracted by the plans to provide services to the Healthy Indiana Plan (HIP) members.

Acute Care Hospital Inpatient

Providers bill claims for the Healthy Indiana Plan (HIP) on the Centers for Medicare & Medicaid Services (CMS) 1450 form (UB-04). Use the Medicare Inpatient Prospective Payment System (IPPS) to calculate payment based on diagnosis-related groups (DRGs). The CMS Medicare Severity (MS) Grouper provides and edits DRGs. The CMS MS Grouper includes tables for all valid diagnoses, procedures, and DRGs. The CMS MS Grouper also includes clinical edits that identify inconsistencies after evaluating a patient's principal diagnosis, any secondary diagnoses, surgical procedures, age, sex, and discharge status for possible errors. Disproportionate-share hospital (DSH), independent medical examination (IME), and new technology are add-ons and not payable.

Payment includes the following:

- Base payment rate
 - The base rate is divided into labor related and non-labor related.
 - The labor-related share is adjusted by the wage index for the area where the hospital is located.
 - The non-labor related share is adjusted by a cost-of-living adjustment factor
- Outlier amount
- Operating expense
- Capital expense

Plans apply Medicaid policy and reimburse for hospital services at the lower of the Medicaid billed amount or the Medicare-allowed rate.

Plans apply Medicaid policy and deny readmissions as appropriate. A readmission within three days following a previous admission and discharge for the same or related condition must be added to the original stay. Readmissions after three days are subject to the Plans medical review policies.

The State follows Medicaid policy and mandates the 72-hour observation rule.

The State follows Medicaid policy for 23-hour outpatient billing requirements. This applies to surgeries with less than a 23-hour hospital stay when Medicare does not allow the procedure as an outpatient, but Medicaid instructs providers to bill surgeries with less than a 23-hour stay as outpatient. An example is anterior cervical disectomy and fusion (ACDF) surgery. This may require manual processing to pay at 130% of the Medicaid rate.

Acute Care Hospital Outpatient

Reimburse outpatient services according to the Medicare Ambulatory Payment Classification (APC) system. Providers bill services on a UB-04 claim form. Each line item on a claim is evaluated for

payment or nonpayment using various criteria. The outcome of the evaluation results in a status indicator assigned to each line. These status indicators determine the applicable payment mechanism. Lines that are determined payable may be priced using multiple mechanisms.

Certain Current Procedural Terminology (CPT^{®1})/Healthcare Common Procedure Coding System (HCPCS) codes are designated payable as an APC payment for which the billed code is mapped into a “grouping” of codes with similar costs. Components of the calculation include the following:

- Groupers that classify CPT/HCPCS codes into appropriate APC categories
- Medicare relative weights assigned to each APC category
- Current National Medicare rate file inclusive of the conversion factor (CF), hospital-specific components such as wage indices, and Outpatient Ratio of Cost to Charge (ORCC). A conversion factor is a dollar amount that serves as a nationally uniform base rate.
- Pricer mechanism that calculates the APC price (the conversion factor times weight), which is inclusive of packaged services
- Applicable pricer-determined outlier adjustment
- Lines that do not receive APC payments are paid under alternative methods
- Certain codes, such as laboratory, are paid using the appropriate Medicare fee schedule
- Certain codes or lines that do not receive payment under the Medicare Outpatient Prospective Payment System (OPPS) due to discontinued codes, codes not recognized by Medicare, and other Medicare outpatient payment guidelines

The following items are not included and are paid based on the Medicare fee-schedule and end-stage renal disease (ESRD) composite rate:

- Lab
- Ambulance
-
- Durable medical equipment (DME)
- Physical therapy (PT)
- Occupational therapy (OT)
- Speech therapy (ST) .
- As part of the APC-based OPPS nonpayment determination, Medicare applies packaging of services. The term packaging means that reimbursement for certain services or supplies is included in the payment for another procedure or service on the same claim. The list of packaged services is very extensive and includes but is not limited to the following:
- Inexpensive drugs
- Medical/surgical supplies
- Recovery room charges

The State follows Medicaid policy and allows the 72-hour observation rule.

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The State follows Medicaid policy for 23-hour outpatient billing requirements. This applies to surgeries with less than a 23-hour hospital stay when Medicare does not allow the procedure as an outpatient but Medicaid instructs providers to bill surgeries with less than 23-hour stay as outpatient. An example is ACDF surgery, which may require manual processing to pay at 130% of Medicaid rate.

Ambulance – Independent and Provider Based

Providers bill claims for ambulance services on a *CMS-1500* form. Payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount. The fee schedule payment for ambulance services equals a base rate for the level of service, plus payment for mileage and the following applicable adjustment factors:

1. Money amount that serves as a nationally uniform base rate, or CF, for all ground ambulance services
2. Relative value unit (RVU) assigned to each type of ground ambulance service
3. Geographic adjustment factor (GAF) for each ambulance fee schedule locality area (geographic practice cost index [GPCI])
4. Nationally uniform loaded mileage rate
5. Additional amount for certain mileage for a rural point-of-pickup

Air Ambulance Service Levels

The base payment rate for the applicable type of air ambulance service is adjusted by the GAF and, when applicable, by the appropriate risk assessment factor (RAF) to determine the amount of payment. Air ambulance services have no CF or RVUs. This amount is compared to the actual charge. The lesser of the charge or the adjusted GAF rate amount is added to the payment rate per mile, multiplied by the number of miles that the beneficiary was transported. When applicable, the appropriate RAF is also applied to the air mileage rate as follows:

1. Nationally uniform base rate for fixed wing transportation and a nationally uniform base rate for rotary wing transportation
2. GAF for each ambulance fee schedule locality area (GPCI)
3. Nationally uniform loaded mileage rate for each type of air service
4. Rural adjustment to the base rate and mileage for services furnished for a rural point-of-pickup

Ground Ambulance Services

Conversion Factor

The conversion factor (CF) is a dollar amount used to develop a base rate for each category of ground ambulance service. Updates to the CF occur annually by the ambulance inflation factor and for other reasons, as necessary.

Relative Value Units

RVUs set a numeric value for ambulance services relative to the value of a base level ambulance service. Because there are marked differences in the resources required to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the unique levels of service. An RVU expresses the constant multiplier for a particular type of service (including, where

appropriate, an emergency response). An RVU of 1 is assigned to the basic life support (BLS) of ground service; higher RVU values are assigned to the other types of ground ambulance services that require more service than BLS.

Anesthesia

Providers bill claims for anesthesia on a *CMS-1500* form. Payment is based on the lesser of the actual charge or the anesthesia fee amount for anesthesia services performed.

The fee amount is calculated based on whether the procedure is medically directed, or medically supervised, by a physician. The vendor pays the lesser of the actual charge or the anesthesia fee schedule amount. Providers must indicate the actual time of the service rendered, in minutes, in the *Units* field of the *CMS-1500* claim form. Plans systematically convert minutes to units (one unit equals 15 minutes) and add the assigned base units in addition to units for modifying circumstances for a total unit value times the anesthesia conversion factor.

$$\text{Base Units} + \text{Time Units} + \text{Additional Units for age (if applicable)} + \text{Additional Units for physical status modifiers (as applicable)} \times \text{Anesthesia Conversion Factor} = \text{Anesthesia Reimbursement Rate}$$

Physicians involved with two concurrent cases with residents can bill the actual time the physician is actually present with the resident during each of two concurrent cases. If the physician medically supervises more than four concurrent anesthesia services, the reimbursement is the fee schedule amount on an anesthesia-specific CF and three base units.

Ambulatory Surgery Center (ASC)

Providers bill claims for ASCs on the *UB-04* claim form. ASCs are reimbursed for covered surgical procedures. Medicare makes additional payments for covered ancillary services. Covered surgical procedures are published in the *Addendum AA* of the OPPS. Covered ancillary services are in the *Addendum BB* of the OPPS.

Assistant at Surgery (Physician)

Reimburse surgery assistants for services (other than assistant-at-surgery services) at 85% of the Medicare physician fee schedule (MPFS) amount allowed for the service.

If a physician furnished the assistant-at-surgery service, reimburse surgery assistants for assistant-at-surgery services at 85% of the MPFS amount allowed for the service under the fee schedule..

Blood

Medicare does not currently provide separate payment for blood and blood products when used during an inpatient hospital stay. Reimbursement for blood and blood products is packaged into the single payment rate for the MS-DRG.

Hospital outpatient departments receive a separate APC payment for blood processing, in addition to the APC payment for the transfusion procedure.

Cancer Hospital Inpatient Services

Cancer hospitals subject to IPPS use the methodology described for acute care hospital inpatient services. For IPPS exempt cancer hospitals, reimbursement is based on the lesser of their actual costs or their *Tax Equity and Fiscal Responsibility Act* (TEFRA) limited costs. Payments are adjusted depending on the difference between these two costs. Routine costs are reimbursed on a *per diem* amount. The hospital supplies a copy of the rate letter from the Medicare intermediary for the *per diem* amount.

Note: *There are currently no cancer or exempt cancer hospitals in the state of Indiana.*

Cancer Hospital Outpatient Services

Reimburse outpatient hospital services according to Medicare APC payment methodology.

Chiropractic Services

Chiropractic services are not listed in Indiana's mandated benefits, nor are chiropractic services listed as a covered service in the HIP legislation. There are no benefits under HIP for the following CPT codes:

- 98940 – Chiropractic manipulative treatment (CMT); spinal, one to two regions
- 98941 – Spinal, three to four regions
- 98942 – Spinal, five regions
- 98943 – Extraspinal, one or more regions
- 98925 – Osteopathic manipulative treatment (OMT), one to two body regions
- 98926 – Three to four body regions
- 98927 – Five to six body regions
- 98928 – Seven to eight body regions involved
- 98929 – Nine to ten body regions involved

Certified Registered Nurse Anesthetist (CRNA)

The allowance for anesthesia service furnished by a CRNA, whether medically directed or not, is based on allowable base and time units.

1. The allowance for an anesthesia service furnished by a medically directed CRNA is based on a fixed percentage of the allowance recognized for the anesthesia service personally performed by the physician alone. If the service is not medically directed, the CRNA is reimbursed at 80% of the allowable charge. The CRNA is reimbursed at 50% of the allowable charge if medically directed.
2. The CF for an anesthesia service furnished by a CRNA not directed by a physician may not exceed the CF for a service personally performed by a physician.

Clinical Nurse Specialist (CNS)

The fee schedule for a CNS is 85% of the MPFS with no patient copayments.

Clinical Psychologist

Reimburse a clinical psychologist for covered services at MPFS.

Reimburse midlevel practitioners at a reduced Medicare reimbursement percentage when providers submit charges with the appropriate modifier.

Clinical Trial Services

Not covered.

Community Mental Health Center (CMHC) and CMHC-owned Critical Access Hospital (CAH)

Reimburse MCHCs the same as any other provider.

Reimburse partial hospitalization services furnished by CMHCs under the hospital prospective payment system.

Co-surgeons and Co-surgeons, Team Surgery

Reimburse each co-surgeon based on the lesser of the actual charges or 62.5% of the MPFS amount. For both surgeons to receive appropriate reimbursement, they must not be assisting each other, but performing distinct and separate parts of the same surgical procedure.

Critical Access Hospital (CAH)

Reimburse a CAH on DRG level like any other rural provider. Davies County Hospital is the model/standard for CAH pricing in Indiana.

Consultation Codes

The State follows Medicare disallowment of consultation codes. Other evaluation and management code reimbursements were increased when these codes were removed. This change was effective on the date the Medicare change became effective.

Diabetic Shoes

Reimburse diabetic shoes (orthotics) according to the DME payment methodology. Providers must include a diagnosis code of diabetes on the claim form for reimbursement.

Drugs

Reimburse outpatient drugs and biologicals that are not included in an outpatient ambulatory payment classification (APC) payment using the CMS average sales price (ASP) fee schedule. Most drugs for patients in a PPS hospital are included in the DRG amount and are not billable. APC payments for outpatient services generally include payment for drugs except for certain new drugs.

Durable Medical Equipment (DME)

Reimburse DME, prosthetics, orthotics, parenteral and enteral nutrition (PEN), and surgical dressings at the rate on the associated Medicare fee schedule.

Only reimburse monthly rentals up to the purchase price of the DME. Reimbursement is not allowed in excess of the purchase price, whether the charge is for rental or purchase.

Reimbursement is based on the Medicare Fee Schedule. If a Medicare rate is not found, the payment defaults to 130% of the Medicaid fee schedule. If a Medicare or Medicaid rate is not found, reimbursement defaults to manual pricing at 90% of billed charges.

Emergency Room

Plans must cover medical screening examinations required under the *Emergency Medical Treatment and Active Labor Act (EMTALA)*. Emergency room providers, including out-of-network emergency room providers, are reimbursed at 100% of the HIP rate, minus copayment (if applicable). If the out-of-network emergency room provider is not a participating IHCP provider at the time service is rendered, the emergency room provider may request retroactive enrollment in order to be reimbursed by the HIP plan; otherwise, the member may be billed for the service.

Emergency Admission – Out of State, Out of Network, and Not an IHCP Provider

If the out-of-network emergency room provider is not an IHCP participating provider at the time service is rendered, the emergency room provider must apply to the IHCP retroactive to the date of service before the plan can reimburse the provider. Applicable copayments apply.

End Stage Renal Disease (ESRD) Facility

Reimburse facilities using the ESRD Pricer available on cms.gov. Services are paid on a per-treatment basis known as composite rate methodology; this includes geographic and patient case-mix adjustments. Routine lab charges are included in the composite rate, and the facility pays the lab. Labs bill nonroutine charges directly and are reimbursed based on the Medicare fee schedule.

Federally Qualified Health Center (FQHC) – Independent and Provider Based

Reimburse FQHCs using the Medicare rates of reimbursement that are paid to non-FQHC/rural health clinic (RHC) providers. The Office of Medicaid Policy and Planning (OMPP) continues to provide

wrap-around payments up to the Medicaid FQHC and RHC Prospective Payment System (PPS) rates as necessary, with year-end settlements based on claims data. Wrap-around payments and year-end settlement payments are determined based on claims paid during the period. For claims paid in a calendar year, any difference between HIP insurer payment and payment under Medicaid PPS is accounted for in the HIP year-end settlement calculations.

Health Professional Shortage Area (HPSA)

No HPSA payments are required for HIP.

Home Health Agencies – Independent and Provider Based

There is not a Medicare rate for less than 60 days of care; therefore, if less than 60 days of care, MCEs will pay 130% Medicaid. If 60 days of care or greater; MCEs will pay the Medicare rate.

Home Infusion

Reimbursement for home infusion is per the Medicare Durable Medical Equipment Prosthetic, Orthotic, and Supplies (DMEPOS) fee schedule for applicable services. Reimburse Part B covered drugs using the Medicare ASP fee schedule.

Hospice

Medicare requires that members enroll in the Hospice program and all other providers bill the hospice for services, The hospice will reimburse the other providers. Providers outside the hospice are no longer allowed to bill Medicare for services provided to the member. Since HIP does not have a separate Hospice program aligned with the Medicare Hospice program, HIP pays 130% of the Medicaid rate.

Hospital Transfer – Acute to Acute and Acute to Post

Providers bill hospital transfer services on a *UB-04* claim form.

Special payment policies apply to hospital transfer cases reimbursed using the MS-DRG methodology. The receiving hospital, or transferee hospital, is paid according to MS-DRG payment methodology. Transferring hospitals are reimbursed a DRG prorated daily rate for each day, not to exceed the full MS-DRG payment amount. The MS-DRG daily rate is determined by dividing the MS-DRG rate by the average length of stay. The full payment to the transferring hospital is the sum of the MS-DRG daily rate and the capital *per diem* rate.

Human Organ Transplant

Under Medicare, the actual organ transplant is reimbursed at the MS-DRG rate, but payment for organ acquisition costs is outside the DRG payment system. Under Medicare, costs are captured in the annual Medicare cost report and an annual settlement is made so that the reimbursement reflects the actual

costs associated with acquiring each organ. A separate schedule is prepared and a separate calculation is performed for each type of organ.

Laboratory – Free Standing and Hospital Based

Providers bill services on a *CMS-1500* or *UB-04* claim form.

Reimburse lab services according to the Medicare clinical lab fee schedule. If a Medicare rate is not found, payment is based on 130% of the Medicaid rate.

When not part of an IP or APC, providers bill lab services on the *CMS-1500* form and reimbursement is calculated using the CMS fee schedules.

Long Term Care Hospital (LTCH)

Providers bill services on a *UB-04* claim form. Reimburse for services using the CMS Medicare LTCH PPS Pricer from cms.gov.

Nurse Practitioner (NP)

The fee schedule for an NP is 85% of the MPFS with no patient copayments.

Physical Therapy, Occupational Therapy, and Speech Therapy (PT, OT and ST)

Reimburse for PT, OT, and ST, including services provided by individual providers, approved clinics, rehabilitation agencies, comprehensive rehabilitation facilities, and home health providers using the applicable Medicare fee schedule rates.

Physician – Medical Doctor (MD) and Doctor of Osteopathy (DO)

Reimburse all professional services according to the allowable rates published in the MPFS. If there is not an allowable amount on the Medicare Fee Schedule, reimburse at 130% of the Medicaid fee schedule.

Physician Assistant (PA)

Reimburse physician assistant services at 85% of the MPFS, except for covered PA assistant at surgery services and services performed in a hospital.

Reimbursement for services performed in a hospital is limited to 75% of the Medicare fee schedule amount.

Physician Shortage Area (PSA)

No PSA payments are required for HIP.

Pregnancy

Pregnancy services are not a benefit under HIP. See [Hoosier Healthwise and HIP MCE Policies and Procedures Manual](#).

Prosthetic Devices

Reimburse for prosthetic devices at 100% of Medicare DMEPOS fee schedule.

Psychiatric Hospital – Inpatient and Outpatient

The Inpatient Psychiatric Facility Prospective Payment System (IPFPPS) is used for freestanding psychiatric hospitals and certified psychiatric units of general acute care hospitals. Calculate reimbursement using the pricer available at [cms.gov](#).

Outpatient reimbursement is based on Medicare APC payment methodology.

Radiology

Reimburse radiology services, including outpatient radiology services, based on the covered CPT code and rate published in the MPFS. If a Medicare rate is not found, reimbursement is based on 130% of the Medicaid fee schedule allowed amount.

Reimburse outpatient radiology services according to the APC rates on outpatient claims.

Radiology furnished to skilled nursing facility (SNF) patients cannot be billed separately for the technical component – payment is included in the comprehensive *per diem*. When an outside entity performs a diagnostic test for an SNF patient, the outside entity must bill the SNF.

Providers bill the professional component for a physician to read a test on a *CMS-1500* claim form. Reimburse for the professional component based on the MPFS.

Rehabilitation Hospital – Inpatient

Calculate reimbursement based on the Inpatient Rehabilitation Facility PPS Pricer available at [cms.gov](#).

The Inpatient Rehabilitation Facility Prospective Payment System (IRFP) is used for freestanding rehabilitation hospitals and certified rehabilitation units of general acute care hospitals. Calculate reimbursement using the IRFP Pricer available at [cms.gov](#).

Rehabilitation Hospital – Outpatient

Reimburse based on Medicare APC payment methodology. (See [Acute Care Hospital Outpatient.](#))

Rural Health Clinic (RHC)

Reimburse services using the Medicare reimbursement rates paid to non-FQHC/RHC providers. The OMPP will continue to provide wrap-around payments up to the Medicaid FQHC and RHC Prospective Payment System (PPS) rates as necessary, with year-end settlements based on claims data. Wrap-around payments and year-end settlement payments are based on claims paid during the period. For claims paid in a calendar year, any difference between the HIP insurer payment and payment under Medicaid PPS is accounted for in the HIP year-end settlement calculations.

RHC – Laboratory or Technical Component of Diagnostic Tests Done in RHCs

Reimburse lab services according to the Medicare clinical lab fee schedule. If a Medicare rate is not found, base payment on 130% of the Medicaid rate.

Skilled Nursing Facility (SNF) – Individual and Provider Based

Reimburse SNF Inpatient services based on the Prospective Payment System (PPS) methodology using the CMS SNF Pricer available at cms.gov. Resource Utilization Group (RUG) and health insurance prospective payment system (HIPPS) codes are used.

Medicare requires a member to have a three-day qualifying inpatient hospital stay within 30 days prior to admission to an SNF. The beneficiary must require skilled nursing care for a condition treated during the qualifying stay, or for a condition that arose while the beneficiary was in the SNF. Medicare uses an inpatient stay as a qualifying event and HIP does not; therefore, HIP reimburses based on the following:

- Medically necessary
- Three-day qualifying event not required
- Reimbursement at 130% Medicaid

Surgical Dressings

The Medicare DMEPOS fee schedule applies to all surgical dressings except those applied incidentally to a physician's professional services, those furnished by a home health agency (HHA), and those applied while a patient is being treated in an outpatient department or as an acute care inpatient.

Swing Bed

Reimburse for a swing bed the same as for any other SNF.

Vaccines

Reimburse vaccines according to the Medicare rate or 130% of the Medicaid fee schedule.

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