INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Medical Practitioner Reimbursement

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 28, 2016	Semiannual update: • Updated the *Resource-Based Relative Value Scale Components* section: • Added Indiana resource-based relative value scale (RBRVS) conversion factor • Specified "Physician" for Medicare Fee Schedule references • Added the advanced nurse practitioner specialties to the *Mid-Level Practitioners* section • Updated the *Surgery-Related Modifiers Affecting Payment* section to include modifier 78 regarding return to surgery • Updated the *Site-of-Service Payment Adjustment* section: – Added place of service 19 – *Off campus-outpatient hospital* – Modified description of place of service 22 • Updated the *Reimbursement for Notification of Pregnancy* section to include information regarding procedure code 99354 TH	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 28, 2017	• Changed Web interChange to Provider Healthcare Portal (Portal) • Updated billing instructions to encompass Portal billing • Changed LPI reference to Provider ID • Changed Indiana*AIM* reference to *Core*MMIS • Removed information about ordering a printed Fee Schedule from the *Introduction* section	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
		• Added bilateral surgery billing and reimbursement procedures and updated the description for modifier 78 in the *Surgery-Related Modifiers Affecting Payment* section • Added the *Provider Preventable Conditions* subheading	

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Introduction

Physicians, limited license practitioners, and other medical practitioners that bill the Indiana Health Coverage Programs (IHCP) on a fee-for-service basis receive a resource-based relative value scale (RBRVS) method of reimbursement.

With the exception of providers contracted with a managed care plan, practitioners are reimbursed at the lower of the submitted charge or the established statewide RBRVS Fee Schedule allowance for the procedure.

Note:	*The IHCP Fee Schedule is located at indianamedicaid.com and can be downloaded free of charge. The Fee Schedule is automatically updated each month or as needed.* *The Fee Schedule contains a complete list of Current Procedural Terminology (CPT®[1]) and Healthcare Common Procedure Coding System (HCPCS) codes, and includes indicators specific to each code, such as program coverage, reimbursement, and prior authorization.*

Resource-Based Relative Value Scale Components

The IHCP Fee Schedule for physician services uses the RBRVS reimbursement methodology. RBRVS was designed to represent the resource costs associated with providing physician services for a more equitable reimbursement structure. RBRVS incorporates three components of physician services:

- *Physician work* – Work is measured by the time and intensity of the physician's effort in providing a service.
- *Practice expense* – Practice costs include items such as office rent, salaries, equipment, and supplies.
- *Malpractice expense* – Malpractice expense is measured by professional liability premium expenses.

The components of the RBRVS reimbursement methodology include the Medicare-based relative value units (RVUs) and a conversion factor. Individual RVUs for each procedure have been developed to represent the resource use associated with individual procedures. The IHCP Fee Schedule is based on statewide RVUs. The RVUs were adjusted to reflect work, practice, and malpractice costs in Indiana. Indiana specifically developed a statewide geographic practice cost index (GPCI) as follows:

- Physician work – 1.000
- Practice expense – 0.922
- Malpractice expense – 0.615

To compute the payment rate for a procedure under the IHCP Fee Schedule, the base RVU must be calculated according to this formula:

Total Base RVUs = (Work RVU × Work GPCI) + (Practice RVU × Practice GPCI) + (Malpractice RVU × Malpractice GPCI)

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

After the total base RVUs are calculated, the payment rate can be determined according to this formula:

Payment Rate = Total Base RVUs × RBRVS Conversion Factor

The Indiana RBRVS conversion factor is $26.8671.

Services are reimbursed using the IHCP Fee Schedule if the following criteria are met:

- CPT coding is used for the service, or the service can be linked to an existing CPT code.
- The service is included in the Medicare Physician Fee Schedule.
- RVUs exist for the service or have been developed for the service.
- The IHCP covers the procedure.

Procedures when the RVU is not appropriate: Most procedures with RVUs on the Medicare Physician Fee Schedule are reimbursed using the IHCP Fee Schedule. Some procedures with RVUs, such as maternity and delivery services, are reimbursed at the lower of the submitted charge or the maximum fee allowed for that procedure, where the maximum fee is not determined using RVUs.

Procedures when the RVU is not available: Procedures on the Medicare Physician Fee Schedule that do not have RVUs to be used with the RBRVS methodology are reimbursed by the IHCP based on a maximum fee or manual pricing methodology. RVUs are not available for some procedures on the Medicare Physician Fee Schedule because the procedure is categorized as one of the following:

- Carrier-priced
- Excluded from the Medicare Physician Fee Schedule
- Not valid for Medicare
- Noncovered by Medicare
- Associated with special restrictions
- Excluded from the definition of physician services

IHCP-covered procedures that fall into one of these categories are reimbursed on the basis of the lower of the submitted charge or maximum allowed fee, or through manual pricing, depending on the specific procedure.

Laboratory procedures billed with modifier 26 – *Professional component* have RVUs and are priced using the IHCP Fee Schedule. All other laboratory procedures are reimbursed according to the Medicare Clinical Laboratory Fee Schedule.

Radiological procedures with RVUs on the Medicare Physician Fee Schedule are reimbursed using the IHCP Fee Schedule. Radiological procedures that do not have an RVU are reimbursed by the IHCP based on a maximum fee allowed or manual pricing methodology. The reimbursement for the technical component of outpatient radiology services billed on an institutional claim (*UB-04* claim form, 837I electronic transaction, or Provider Healthcare Portal institutional claim) is equal to the technical component rates identified on the IHCP Fee Schedule, resulting in the consistent technical component reimbursement for radiology services across all Medicaid providers.

Anesthesia services are also excluded from the RBRVS reimbursement methodology. The IHCP reimburses for anesthesiology services according to a statewide calculation on the total base units, time units, and add-on units, and based on specific modifiers for the procedure, multiplied by the anesthesia conversion factor established by the IHCP.

Special Payment Situations

Under RBRVS pricing, certain situations result in special payment provisions within the IHCP Fee Schedule. The RBRVS payment methodology includes the use of certain pricing modifiers and other policies that have an impact on the payment amount.

Providers should place modifiers after the procedure code in field 24D on the *CMS-1500* claim form or in the equivalent modifier field on the 837P electronic transaction or Provider Healthcare Portal professional claim. The *Claim Submission and Processing* module provides additional information about modifiers.

Mid-Level Practitioners

To reflect differences in education and training, reimbursement for the following provider types under the IHCP Fee Schedule is based on less than 100% of the Fee Schedule amount:

- Independently practicing advanced practice nurses, enrolled as type 09, specialties 090, 091, 092, 093, and 095:
  - Pediatric nurse practitioners
  - Obstetric nurse practitioners
  - Family nurse practitioners
  - Nurse practitioners (other, such as clinical nurse specialists)
  - Certified nurse midwives
- Independently practicing respiratory therapists
- Certified registered nurse anesthetists (CRNAs), enrolled as type 09, specialty 094
- Psychologists, other than health service providers in psychology (HSPPs), certified social workers, and certified clinical social workers providing outpatient mental health services in a physician-directed outpatient mental health facility in accordance with *Indiana Administrative Code 405 IAC 5-20-8*
- Licensed marriage and family therapists, and mental health counselors

CRNAs are reimbursed at 60% of the physician fee; all other mid-level practitioners mentioned in the preceding list are reimbursed at 75% of the physician fee.

In addition, the following providers are reimbursed at an adjusted rate:

- Certified physical therapist assistants – Identified procedures can be performed by a certified physical therapist assistant. These services must be billed with modifier HM and are reimbursed at 75% of the reimbursement for a physical therapist.
- Speech language pathologist aides – Identified procedures can be performed by speech language pathologist aides. These services must be billed with the modifier HM and are reimbursed at 75% of the reimbursement for a speech pathologist.

Providers must submit claims with the appropriate modifier for the system to apply the correct reduction.

IHCP-enrolled mid-level practitioners associated with a group must use a unique, individual National Provider Identifier (NPI) when billing. Mid-level practitioners without individual NPIs must use the supervising physician's NPI in the **rendering provider** field (in the bottom portion of field 24J on the *CMS-1500* claim form or equivalent field of the electronic claim), along with the appropriate modifier. The group provider NPI is entered in the **billing provider** field (in field 33a on the *CMS-1500* claim form or equivalent field of the electronic claim).

> *Note: Psychologists, social workers, licensed marriage and family therapists, physical therapist assistants, and mental health counselors are not enrolled in the IHCP. Supervising physicians or HSPP must submit claims on their behalf.*

Nurse Practitioners

The IHCP reimburses independently practicing nurse practitioners at 75% of the rate on file. The nurse practitioner must enter his or her rendering NPI in the **rendering provider** field (in the bottom portion of field 24J on the *CMS-1500* claim form or equivalent field of the electronic claim). The billing NPI must be entered in the **billing provider** field (in field 33a on the *CMS-1500* claim form or equivalent field of the electronic claim).

Nurse practitioners not individually enrolled in the IHCP, and clinical nurse specialists employed by physicians in a physician-directed group or clinic, bill services with the SA modifier and enter the physician rendering NPI in the **rendering provider** field. The billing NPI must be entered in the **billing provider** field. The IHCP reimburses these providers at 100% of the Medicaid-allowed amount.

Nurse practitioners with an individual NPI and an IHCP-issued Provider ID, who are employed by a physician, can bill using their rendering NPI in the **rendering provider** field. The group NPI must be entered in the **billing provider** field. The IHCP reimburses these providers at 100% of the Medicaid-allowed amount.

Providers cannot bill separately for nurse practitioner services in outpatient hospital settings and should include these services in the hospital outpatient reimbursement rate.

Physician Assistants

Physician assistants are not separately enrolled in the IHCP. The physician's rendering NPI must be entered in the **rendering provider** field (in the bottom portion of field 24J on the *CMS-1500* claim form or equivalent field of the electronic claim). The physician's billing NPI must be entered in the **billing provider** field (in field 33a on the *CMS-1500* claim form or equivalent field of the electronic claim).

Providers should bill physician assistant services with the HN – *Bachelor's degree* or HO – *Master's degree* modifier applicable to the level of education of the physician assistant. The IHCP reimburses these providers at 100% of the Medicaid-allowed amount. However, when a physician assistant provides assistant surgeon services, the provider should use modifier AS, instead of the HN or HO modifier. Reimbursement for the assistant at surgery is 20% of the rate on file.

Surgery-Related Modifiers Affecting Payment

In addition to the payment differential for mid-level practitioners, the following pricing modifiers and policies related to surgical services billed on the professional claim have an impact on the payment amount:

- *Assistant surgeon modifier* – Providers that bill as surgical assistants must use modifiers 80, 81, or 82. Payment is made at 20% of the IHCP Fee Schedule amount.

  > *Note: Providers billing for physician assistants acting as assistant surgeons should use the AS modifier.*

- *Cosurgeon modifier* – Providers that bill as cosurgeons must use modifier 62. The IHCP reimburses these claims at 62.5% of the IHCP Fee Schedule amount.

- *Intraoperative services only* – Physicians who provide services for only the intraoperative component of surgery, such as services that are usually considered part of the surgical procedure, are reimbursed a percentage of the IHCP Fee Schedule amount for the surgical procedure code. Adding modifier 54 – *Surgical care only* to the procedure code identifies when one physician performs a surgical procedure and another physician provides preoperative and postoperative management of surgical services.
- *Postoperative services only* – Providers that perform postoperative services but did not perform the surgery must bill using modifier 55 – *Postoperative management only*. These providers are reimbursed a percentage of the IHCP Fee Schedule amount. The percentage adjustment for modifiers 54 and 55 is specific to the surgical procedure.
- *Preoperative care only* – The IHCP does not recognize modifier 56 – *Preoperative care only* as a valid modifier. If a provider bills modifier 56, the Core Medicaid Management Information System (*Core*MMIS) denies the detail for modifier 56 and generates an invalid modifier message.
- *Return to surgery* – If a patient is returned to surgery for a related procedure during the postoperative period and billed using modifier 78 – *Return to the operating/procedure room for a related procedure during the postoperative period*, the percentage adjustment for modifier 78 is specific to the surgical procedure.
- *Bilateral surgery* – When billing for bilateral procedures, modifier 50 must be reported on the claim if the procedure code itself is not described as a bilateral procedure. If the procedure code is described as bilateral, modifier 50 should not be reported. Effective February 13, 2017, IHCP reimbursement for bilateral procedures is based on the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule relative value file status indicators, as described in the *Surgical Services* module.
- *Multiple procedures* – When multiple surgical procedures, identified by modifier 51, are performed by the same physician in the same operative session, multiple surgery reductions apply to the procedures based on the following adjustments for physician claims:
  - 100% of the global fee for the most expensive procedure
  - 50% of the global fee for the second most expensive procedure
  - 25% of the global fee for the remaining procedures

For more information on surgical services, including details about using these modifiers, see the *Surgical Services* module.

Provider Preventable Conditions

The IHCP does not cover surgical or other invasive procedures to treat particular medical conditions when a practitioner performs a surgery or invasive procedure erroneously. The IHCP also does not cover services related to these noncovered procedures, including all services provided in the operating room when an error occurs. All providers in the operating room when the error occurs, that could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

The following provider preventable conditions (PPC) modifiers must be submitted on physician, physician crossover, and physician crossover Medicare Replacement Plan claims indicating errors:

- PA – *Surgery wrong body part*
- PB – *Surgery wrong patient*
- PC – *Wrong surgery on patient*

Site-of-Service Payment Adjustment

When procedures that are normally performed in a physician's office are provided in outpatient places of service 19 – *Off campus-outpatient hospital*, 22 – *On campus-outpatient hospital*, 23 – *Emergency room*, or 62 – *Comprehensive outpatient rehabilitation facility*, these procedures are subject to a site-of-service payment adjustment that is 80% of the practice expense component of the statewide IHCP Fee Schedule.

Reimbursement for Notification of Pregnancy

Recognized providers that complete and submit (via the Provider Healthcare Portal) a Notification of Pregnancy (NOP) form for a managed care member – including current and accurate demographics, any high-risk pregnancy indicators identified at the office visit, and basic pregnancy information – may be eligible for a $60 incentive payment. The procedure code used to provide payment, 99354 TH, is noncovered for fee-for-service members.

For questions regarding completion of the NOP, please contact your IHCP Provider Relations field consultant. For more information on the NOP, see the *Obstetrical and Gynecological Services* module and the *Notification for Pregnancy* page at indianamedicaid.com.

B-Bundled Codes Not Separately Reimbursable

The IHCP does not separately reimburse certain CPT and HCPCS codes with a designated status of "B" (indicating a bundled procedure) by the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule Relative Value File. B-bundled codes are not reimbursable services, regardless of whether they are billed alone or in conjunction with other services on the same date.