Chapter 7: Reimbursement Methodologies
## Chapter 7: Revision History

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<td>May 2009</td>
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<td>• Updated <a href="#">Dental Services: General Information</a> section</td>
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Section 1: Introduction to Reimbursement Methodologies

General Information

This chapter presents the reimbursement methodologies used by the Indiana Health Coverage Programs (IHCP) for services provided by IHCP-enrolled providers.

The claims pricing process calculates the IHCP-allowed amount for claims based on claim type and defined pricing methodologies for each provider type. These pricing methodologies include the following:

• Cost-based and case mix reimbursement
• Diagnosis-related group (DRG)
• Home health services
• IHCP Fee Schedule
• Laboratory services
• Manually priced services
• Medicare and IHCP crossover coinsurance and deductible
• Outpatient ambulatory surgical center (ASC) flat rate
• Pharmacy services
• Resource-based relative value scale (RBRVS)

The reimbursement methodologies outlined in this chapter are found in 405 IAC 1-8 through 405 IAC 1-11.5.

Chapter 8: Billing Instructions provides specific billing guidelines.

Hoosier Healthwise or Care Select Considerations

The Hoosier Healthwise managed care organizations (MCOs) reimburse in-network providers as stated in their contracts. In the absence of another arrangement, the Hoosier Healthwise MCOs reimburse out-of-network providers according to the IHCP Fee Schedule.

Care Select providers are also reimbursed according to the IHCP Fee Schedule.

National Provider Identifier Considerations

Claims received on or after October 1, 2009, will be rejected if healthcare providers do not submit their National Provider Identifiers (NPIs) on the claims. Nonhealthcare, atypical providers will continue to bill using their LPIs.

All healthcare providers submitting Health Insurance Portability and Accountability Act (HIPAA) standard transactions and paper claims must include an NPI when submitted to the IHCP.
All providers, except atypical providers, that submit claims to the IHCP, must obtain and report their NPI to the IHCP. Without the NPI, these claims are denied. Please refer to Chapter 4 for details on reporting the NPI.
Section 2: Hospital Inpatient Services

General Information

All Indiana Health Coverage Programs (IHCP) acute care hospitals, municipal county hospitals, community mental health centers (CMHCs), state psychiatric hospitals, and private psychiatric hospitals should refer to IHCP State Plan: Attachment 4.19A for information about participation in the following payment programs:

- Hospital Care for the Indigent (HCI) Payment
- Municipal County Hospital Indiana Medicaid Shortfall Payment
- Indiana Medicaid Disproportionate Share Hospital (DSH) Payment
- Safety-Net Hospital Payment
- Supplemental Private Hospital Adjustment

Inpatient Services

The IHCP reimburses for hospital inpatient claims on a Level of Care (LOC)/diagnosis-related group (DRG) hybrid reimbursement system for hospitals. This hybrid system consists of the following two distinct reimbursement methodologies:

- A DRG system that reimburses a per case rate according to diagnoses, procedures, age, gender, and discharge status
- An LOC system that reimburses psychiatric, burn, and rehabilitation cases on a per diem basis

The LOC portion of the methodology was developed in conjunction with the DRG reimbursement due to wide variances in length of stay and costs associated with some care provided.

Reimbursement for inpatient hospital services under the hybrid system is composed of the following components:

- DRG rate per case or LOC per diem
- Capital rate
- Medical education rate, if applicable
- Outlier payment, if applicable

The following describes the various key elements of the inpatient reimbursement methodology. The section is divided into the following subsections:

- DRG reimbursement system
- LOC reimbursement system
- DRG Base Rate for Children’s Hospitals
- Reimbursement for Capital Costs
- Reimbursement for medical educational costs
- Transfers
• Readmissions
• Inpatient Stays Less than 24 Hours
• Outpatient Service within Three Days of an Inpatient Stay
• Outpatient Service within Three Days of a 24-Hour Inpatient Stay
• Hoosier Healthwise Package C Exceptions to DRG and LOC Reimbursement Systems
• Long-Term Acute Care (LTAC) reimbursement
• Medicare Exhaust Claims
• Submitted Charges and Medicaid-Allowed Amount

Diagnosis-Related Group Reimbursement System

DRGs are the basis for payments to hospitals under a prospective payment system. DRGs group hospital inpatient cases that are clinically similar and relatively homogeneous with respect to resource use.

The IHCP used claims data to base the DRG system. The system is a prospective cost-based method that contains no form of year-end settlement.

The DRG reimbursement rates are intended to cover all inpatient hospital costs, including the costs of inpatient routine care and ancillary services. Additional payments to hospitals are as follows:

• Capital-related costs
• Direct medical education costs, if applicable

Hospitals cannot bill IHCP members for the difference between payments and actual charges, except for those conditions stated in Chapter 4 of this manual.

The critical components of a DRG inpatient reimbursement system are as follows:

• The classification system, known as the grouper
• The calculation of the relative weights
• The calculation of the DRG base rate
• Length of inpatient stay
• Outlier payments, which use facility-specific cost-to-charge ratios, capital rates, and medical education rates, if applicable

Present on Admission Indicator for Hospital Acquired Conditions

Effective for inpatient and inpatient crossover claims with a ‘From’ date of service on or after October 1, 2009, the Indiana Health Coverage Programs (IHCP) will adopt a hospital-acquired conditions (HAC) policy for Medicaid claims using our existing version 18.0 of the All Patient Diagnosis-Related Group (AP DRG) grouper. Hospitals are required to report whether each diagnosis on a Medicaid claim was present on admission. Claims submitted without the required present on admission (POA) indicators will be denied. For claims containing secondary diagnoses that are included in the list of HACs in Table 7.1 and for which the condition was not present on admission, the HAC secondary diagnosis will not be used for AP DRG grouping. That is, the claim will be paid as though any secondary diagnoses included in Table 7.1 were not present on the claim.
<table>
<thead>
<tr>
<th>Description</th>
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<tr>
<td>Foreign Object Retained After Surgery</td>
<td>998.4 (CC) and 998.7 (CC)</td>
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<td>Air Embolism</td>
<td>999.1 (MCC)</td>
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<tr>
<td>Blood Incompatibility</td>
<td>999.6 (CC)</td>
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<td>Pressure Ulcers Stages III and IV</td>
<td>707.23 (MCC) and 707.24 (MCC)</td>
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<td>Falls and Trauma</td>
<td>CC – Complicating Condition</td>
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<tr>
<td></td>
<td>MCC – Major Complicating Condition</td>
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<td>Fractures</td>
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<td>Dislocations</td>
<td>830 – 839</td>
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<td>Intracranial Injuries</td>
<td>850 – 854</td>
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<td>Crushing Injuries</td>
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<td>Burns</td>
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<tr>
<td>Electric Shock</td>
<td>991 – 994</td>
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<td>Catheter-Associated Urinary Tract Infection (UTI)</td>
<td>996.64 (CC), and excludes the following from acting as a CC/MCC:</td>
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<td>• CC – 112.2, 590.10, 590.3, 590.80, 590.81, 595.0, 597.0, 599.0</td>
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<td>• MCC – 590.11, 590.2</td>
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<td>Vascular Catheter-Associated Infection</td>
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<td>Manifestations of Poor Glycemic Control</td>
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<td>• 250.10 – 250.13</td>
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<td>• 249.20 – 249.21</td>
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<tr>
<td></td>
<td>CC –</td>
</tr>
<tr>
<td></td>
<td>• 251.0</td>
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<td>519.2 (MCC) and one of the following procedure codes:</td>
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<td>Surgical Site Infection Following Certain Orthopedic Procedures</td>
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<td>• 81.23 – 81.24</td>
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<td>• 81.83</td>
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<td>• 44.95</td>
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<td>Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain</td>
<td>453.40 – 453.42 (MCC) or 415.11 (MCC)</td>
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**Notes:** If a claim contains a hospital acquired condition diagnosis with a POA indicator of “U” or “N,” the HAC diagnosis will be suppressed when the claim processes through the DRG grouper. The OMPP will not pay the complicating condition/major complicating condition (CC/MCC) for HACs.

The POA indicator of “1” is only applicable to diagnoses exempt from POA reporting and should not be applied to any codes on the HAC list. Any claims using the POA indicator of “1” with a nonexempt diagnosis will deny, and providers will need to correct and resubmit the claim for reimbursement.

Claims containing HAC diagnoses with POA indicators of “Y” or “W” will process through the AP DRG grouper and process per normal inpatient policy.

Claims submitted by a nonexempt hospital that do not include a POA indicator for the principal and any secondary diagnoses will be denied. The provider will need to correct and resubmit the claim.
Present on Admission Indicator

POA indicator reporting is mandatory for all Medicaid claims involving inpatient admission to general acute care hospitals with a primary specialty of Acute Care – 010. However, the following types of hospitals are EXEMPT from the Medicaid HAC policy and POA indicator reporting:

- Critical access hospitals (CAHs)
- Long-term acute care hospitals (LTACs) (primary specialty 013)
- Inpatient psychiatric hospitals (primary specialty 011)
- Inpatient rehabilitation facilities (primary specialty 012)

Psychiatric or rehabilitation units of acute care hospitals, also known as a distinct part of an acute care hospital, enrolled with primary specialty 010 are required to submit the POA indicator on their claims.

The list of critical access hospitals was identified using information obtained from Medicare. Hospitals that are not sure of their CAH status should contact the HP Provider Enrollment Unit at 1-877-707-5750 for confirmation.

POA is defined as “present” at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting).

The Centers for Medicare & Medicaid Services (CMS) does not require a POA indicator for an external cause of injury code unless it is being reported as an “other diagnosis.”

Therefore, the IHCP does not require a POA indicator in the External Cause of Injury Field Locator 72. If a POA indicator is entered in the External Cause of Injury field, it will be ignored and not used for AP DRG grouping.

Hospital Acquired Condition List

The current list of HACs was published by CMS in the August 19, 2008, FFY 2009 Inpatient Prospective Payment System final rule (73 FR 48471) and includes diagnoses listed in Chapter 8. The IHCP will continue to follow CMS’ HAC determinations, including any future additions or changes to the current list of HAC conditions, as well as diagnosis codes that are exempt from HAC reporting.


For complete billing instructions for POA and HAC, see Chapter 8 of this manual.

Grouper

Groupers classify inpatient cases into categories that represent similar resource consumption during treatment. The categories are termed DRGs.

Each discharge is assigned to one DRG, regardless of the number of services furnished or the number of days of care provided. DRG assignment is based on the physician’s record of the patient’s principal diagnosis, any additional diagnoses, procedures performed, patient age, gender, and discharge status. The diagnoses and procedures information is expressed using International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes with the highest level of specificity possible. Providers must use a fourth or fifth digit when one is identified in the ICD-9-CM manual. Failure to
properly specify this data may result in inaccurate payment for a submitted claim or in a suspended claim, which also may delay payment.

Indiana selected the All-Patient (AP) DRG Grouper as the Grouper for the DRG system because the AP DRG Grouper more appropriately addresses the resource consumption of the IHCP, such as the non-Medicare population.

Mapper

The IHCP uses Version 18 of the AP DRG Grouper. The AP DRG mapper, a product of HSS, Inc., has been installed to allow providers to bill current ICD-9-CM codes despite using a different version of the AP DRG grouper. The mapper converts current ICD-9-CM codes to the appropriate codes used by Version 18.

Relative Weights

Each DRG assigned by the Grouper has a corresponding relative weight. Relative weights are numeric values that reflect the relative resource consumption for the DRGs to which they are assigned. Taking the average cost for a DRG and dividing by the average cost of all DRGs creates the weight.

DRG Base Rate

The DRG base rate is the payment rate used to reimburse hospitals for both routine and ancillary costs associated with inpatient care. The DRG rate is determined by a fixed statewide base rate, which is the rate per IHCP stay multiplied by the relative weight:

\[
\text{Statewide Base Rate} \times \text{Relative Weight} = \text{DRG Rate}
\]

Statewide base rates change periodically, and providers must consider the date of service of claims when calculating payment using the formula.

IHCP Stay

A period of inpatient care that includes 24 hours or more in the hospital and is reimbursable under the IHCP is considered an IHCP stay. The statewide base rate is determined using hospital cost reports and was inflated using the Global Insight Hospital Market Basket Index. Providers can obtain current base rate information by contacting HP Customer Assistance.

DRG Outlier Payment Policies

The state of Indiana defines a DRG cost outlier case as an IHCP stay that exceeds a predetermined threshold, currently defined as the greater of twice the DRG or $34,425. Day outliers (IHCP days that exceed a predetermined threshold) are not reimbursed under the DRG outlier payment policy.

Under a DRG hybrid reimbursement system, the need for an outlier policy is significantly reduced, because cases that traditionally are classified as outliers, such as burn, psychiatric, and rehabilitative care, are reimbursed under the LOC component. The hybrid system, however, does not completely eliminate the need for appropriate outlier policies and reimbursement rates. Outlier payments are available for all qualifying cases reimbursed under the DRG system.

To determine the outlier payment amounts, costs per IHCP stay are calculated by multiplying a hospital-specific cost-to-charge ratio by allowed charges. The payment is a percentage of the difference between the prospective cost per stay and the outlier threshold indicated above. The
percentage, or marginal cost factor, has been determined at 60 percent. Hospitals are notified
individually of the specific cost-to-charge ratios that must be used to determine outlier payments for
DRGs and the LOC system (burn only). Cost-to-charge ratios are calculated only during rebasing and
recalibration periods, except for new providers.

The IHCP allowed amount is calculated as follows:

\[
\text{DRG Rate} + \text{Capital Costs Payment} + \text{Medical Education Costs Payment (if applicable)} + \text{Outlier Payment (if applicable)}
\]

The capital costs payment is a statewide per diem, and payment is based on the average length of stay
for the assigned DRG. The capital payment is outlined after the discussion on the LOC reimbursement
system as it pertains to the DRG and LOC methodologies. LTAC providers do not receive separate
capital reimbursement.

The medical education costs payment is a provider-specific per diem rate based on the average length
of stay for the assigned DRG. The medical education costs payment is outlined later in this chapter,
after the explanation of the LOC reimbursement system as it pertains to the DRG and LOC
methodologies.

**Level of Care Reimbursement System**

Certain cases are excluded from the DRG rate methodology due to wide variances in length of stay and
severity of resource consumption. Under the traditional DRG reimbursement systems, such cases are
generally regarded as outliers. A hybrid system, however, incorporates a distinct reimbursement
mechanism to accommodate these cases. This reimbursement mechanism is known as an LOC system,
and it reimburses hospitals on a per diem basis. Three types of cases are reimbursed under the LOC
system:

- Burn cases
- Psychiatric cases
- Rehabilitation cases

The LOC reimbursement rates represent all payments, excluding any applicable disproportionate share
payments, to a hospital for all inpatient costs, costs of routine inpatient care, and ancillary services.
Additional payments to hospitals are provided for the following:

- Capital costs
- Burn outlier costs, if applicable
- Medical education costs, if applicable

Hospitals cannot bill IHCP members for the difference between payments and actual charges, except
under those conditions stated in Chapter 4.

Claims are processed through the AP DRG Grouper to be classified into appropriate DRGs. Some
claims are classified by specialty type, such as freestanding and distinct-part unit psychiatric and
rehabilitation facilities. Claims classified into the following DRGs are excluded from the DRG system
and reimbursed under the LOC system as follows:

- DRGs excluded for burn cases – 456 through 459, 472, and 821 through 828
- DRGs excluded for psychiatric cases – 424 through 432, DRG 429 excludes diagnoses 317XX
  through 319XX
- DRGs excluded for rehabilitation cases – 462
Level of Care payment rates: LOC rates are established using costs derived from cost-to-charge ratio adjusted claims data for cases having the DRG numbers shown. The cost per diem is calculated for each hospital in each of the four LOC groups. These per diem payments are based on the weighted median per diem cost, calculated based on the number of discharges. The four LOC payment rate types are as follows:

- Psychiatric
- Burn/1
- Burn/2
- Rehabilitation

Burn cases are divided into two groups, Burn/1 and Burn/2, based on the costs incurred by hospitals to treat burn patients. These rates handle severe burn cases that call for specialized facilities and procedures.

Burn/1 facilities have been identified based on the burn services provided in certified burn care facilities and the cost of those services. These facilities consistently provide more intensive and more costly burn care than other Indiana hospitals, and are the only hospitals eligible to bill and receive reimbursement at the Burn/1 rate. The certified Burn/1 facilities are the following:

- Wishard Memorial Hospital
- Clarian Health Partners
- Saint Joseph’s Hospital of Fort Wayne
- University Medical Center (Louisville)

All other hospitals are reimbursed at the Burn/2 rate.

Level of Care Outlier Payment Policies

Under the LOC system, the IHCP makes outlier payments for burn cases that exceed established thresholds. The state of Indiana defines an LOC cost outlier as an IHCP hospital day stay with a cost per day that exceeds twice the burn rate.

To determine the outlier payment amounts, costs per IHCP stay are calculated by multiplying a hospital-specific cost-to-charge ratio by allowed charges. The outlier payment is a percentage of the difference between the prospective cost per day and the outlier threshold for each covered day of care. The percentage, or marginal cost factor, is 60 percent. The total payment is the sum of LOC rate; outlier payment, if applicable; capital rate; and medical education, if applicable, for each covered day of care.

The IHCP-allowed amount is calculated as follows:

\[ \text{LOC Rate} + \text{Capital Costs Payment} + \text{Outlier Payment (if applicable)} + \text{Medical Education Costs Payment (if applicable)} \]
**DRG Base Rate for Children’s Hospitals**

405 IAC 1-10.5-3 allows the Office of Medicaid Policy and Planning (OMPP) to establish separate base rates for children’s hospitals to the extent necessary to reflect significant differences in cost. By definition, a children’s hospital is a freestanding, general, acute care hospital licensed under IC 16-21 that meets the following criteria:

- Designated by the Medicare program as a children’s hospital
- Furnishes services to inpatients who are predominately members younger than 18 years old, as determined using the same criteria used by the Medicare program to determine whether a hospital’s services are furnished to inpatients who are predominately younger than 18 years old

Children’s hospitals incur significantly higher IHCP costs than other hospitals, even after accounting for differences in the case mix of patients. At this time, the children’s hospitals are the following:

- Clarian Health Partners/Riley Hospital for Children
- Children’s Memorial Hospital of Chicago

Based on the review of costs for facilities meeting this definition, the DRG base rate for children’s hospitals is 120 percent of the standard DRG base rate.

**Reimbursement for Capital Costs**

Inpatient hospital stays are reimbursed using the DRG or LOC rate, the capital rates, and the medical education rates and outlier payments, if applicable. This subsection describes the methodology for calculation of capital (per diem) rates under the DRG and LOC systems.

Facilities are reimbursed a flat, statewide per diem rate for capital costs. This payment rate is calculated by using facility documentation and the Global Insight, Inc. Hospital Market Basket Index.

The capital payment rate for inpatient care reimbursed under the DRG methodology is the per diem capital rate, multiplied by the average length of stay for all cases within the particular DRG. For cases reimbursed under the LOC system, facilities are reimbursed the per diem capital rate for each covered day of care.

The IHCP does not determine a separate capital per diem rate for freestanding and acute care hospitals with distinct psychiatric units. All inpatient care, regardless of setting, receives the same capital per diem rate.

**Reimbursement for Medical Educational Costs**

The IHCP reimburses medical education costs on a hospital-specific, per diem basis. Medical education payment rates are based on the daily cost per resident, multiplied by the number of residents. The resident cost per day is calculated using each facility’s cost reports. The number of residents is based on the most recent cost report data. The most recent data is used to indicate the number of residents to ensure that the payment rate established is most indicative of the number of residents at each hospital.

**Medical Education under the DRG System**

Medical education payments for IHCP stays under the DRG methodology are equal to the medical education per diem rate multiplied by the average length of stay for the DRG.
**Medical Education under the Level of Care System**

IHCP stays under the LOC system are reimbursed using the medical education *per diem* rate for each covered day of care.

**Qualification for Medical Education Payments**

Institutional providers must continue to submit current CMS-2552 cost reports. For those providers receiving medical education payments, adjustments in the payment rate are made based on changes in the full-time equivalent (FTE) count of interns and residents. Payment for medical education is provided only to those hospitals that operate medical education programs. Hospitals that discontinue or downsize the medical education programs must promptly notify the OMPP at the following address:

**Hospital Reimbursement Section**  
**Indiana Office of Medicaid Policy and Planning**  
**402 West Washington Street MS07, W-382**  
**Indianapolis, IN 46204**

**Transfers**

Special payment policies apply to transfer cases paid using the DRG methodology. The receiving hospital, or transferee hospital, is reimbursed according to the DRG or LOC methodology, whichever is applicable. Transferring hospitals are reimbursed a DRG-prorated daily rate for each day, not to exceed the full DRG amount. The IHCP calculates the DRG daily rate by dividing the DRG rate by the average length of stay. The full payment to the transferring hospital is the sum of the DRG daily rate, the capital *per diem* rate (up to the DRG average length of stay), and the medical education *per diem* rate (up to the DRG average length of stay). Transferring hospitals are eligible for outlier payments.

To ensure accurate reimbursement, the appropriate discharge status code must be placed in field 17 of the *UB-04* claim form:

- **Patient status 02** – Discharged or transferred to another short-term general hospital for inpatient care.
- **Patient status 03** – Discharged or transferred to skilled nursing facility (SNF).
- **Patient status 04** – Discharged or transferred to an intermediate care facility (ICF).
- **Patient status 05** – Discharged or transferred to a designated cancer center or children’s hospital.
- **Patient status 06** – Discharged or transferred to home under care of organized home health service organization.
- **Patient status 08** – Discharged or transferred to home under care of a home intravenous provider.
- **Patient status 43** – Discharged or transferred to a federal healthcare facility.
- **Patient status 61** – Discharged or transferred within this institution to hospital-based Medicare swing bed.
- **Patient status 62** – Discharged or transferred to another rehabilitation facility including discharge planning units of hospital.
- **Patient status 63** – Discharged or transferred to a long-term care hospital.
- **Patient status 64** – Discharged or transferred to a nursing facility – Medicaid-certified but not Medicare-certified.
• Patient status 65 – Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
• Patient status 66 – Discharged or transferred to a Critical Access Hospital.
• Patient status 70 – Discharged or transferred to another type of healthcare institution not defined elsewhere in code list.
• Patient status 71 – Discharged, transferred, or referred to another institution for outpatient services when specified by the discharge plan of care.
• Patient status 72 – Discharged, transferred, or referred within this facility for outpatient services when specified by the discharge plan of care.

Certain DRGs include transfer cases only. The DRGs that include only transfer cases are as follows:
• 639 – Neonate, transferred less than 5 days old, born here
• 640 – Neonate, transferred less than 5 days old, not born here

Reimbursement for the above DRGs is equal to the specified DRG rate.

All transfers are subject to retrospective review to ensure appropriate billing and payment. See Chapter 8 of this manual for specific instructions on billing transfers.

Providers do not receive separate DRG payments for IHCP patients that return from a transferee hospital. Specifically, this policy applies when a patient returns to a hospital from which they were previously transferred out for the same illness.

Providers must combine the original admission and subsequent return stay on one claim for billing purposes.

Note: Claims grouping to DRG 639 – Neonate, transferred less than 5 days old, born here or 640 – Neonate, transferred less than 5 days old, not born here are exempt from the transfer reimbursement policies.

Readmissions

A readmission is defined as a hospital admission within three days following a previous hospital admission and discharge for the same or related condition. Readmissions greater than three days following a previous hospital discharge are treated as separate stays for payment purposes, but are subject to medical review. If it is determined that a discharge is premature, payment made as a result of the discharge or readmission may be subject to recoupment.

Providers should bill one inpatient claim when a patient is readmitted to their facility within three days of a previous inpatient discharge (the stays should be consolidated on one claim) for the same or related diagnosis.

Note: Same or related refers to the principal diagnosis code and is based on the first three digits of the ICD-9-CM code. If a second inpatient claim is billed for the same member with the same or related principal diagnosis code, the second claim will be denied.
**Inpatient Stays Less than 24 Hours**

Providers should bill any inpatient stay that is less than 24 hours as an outpatient service. Inpatient stays less than 24 hours that are billed as an inpatient service will be denied.

Claims grouping to DRG 637 – Neonate, died w/in one day of birth, born here or DRG 638 – Neonate, died w/in one day of birth, not born here are exempt from this policy because they are specific to one-day stays.

**Note:** Providers that follow this rule and bill for outpatient services when a patient has been admitted as an inpatient will not be viewed as being in noncompliance with program policies concerning internal records and billing requirements. The OMPP will not take action against a provider for adhering to the agency’s billing requirements for inpatient stays of fewer than 24 hours, because this is in compliance with the Indiana regulation and billing requirements. Also, providers do not need to amend their medical recordkeeping to comply with these changes. Medical records that originally indicated an inpatient stay of less than 24 hours should not be amended.

**Outpatient Service within Three Days of an Inpatient Stay**

Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or related diagnosis, are considered part of the corresponding inpatient admission. Providers are required to submit an inpatient claim only when the services, outpatient and inpatient, occur at their facility.

**Note:** Same or related refers to the principal diagnosis code and is based on the first three digits of the ICD-9-CM code.

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will deny with an explanation of benefits (EOB) code indicating that the provider should bill services on the inpatient claim. The provider should void the outpatient claim and resubmit one inpatient claim.

If an outpatient claim is submitted subsequent to the payment of an inpatient claim, the outpatient claim will deny with an EOB indicating that the inpatient claim may be adjusted to reflect the outpatient services provided to the patient.

This policy is not applicable when the outpatient and inpatient services are provided by different facilities.

**Outpatient Service within Three Days of a 24-Hour Inpatient Stay**

Outpatient services within three days, preceding a less than 24-hour inpatient stay, are billed as an outpatient service. Because the inpatient service was less than 24 hours, it too should be billed as an outpatient service.
Hoosier Healthwise Package C Exceptions to DRG and LOC Reimbursement Systems

The following are exceptions to the DRG and LOC reimbursement systems for Hoosier Healthwise Package C members:

• Organ transplants are not covered for Hoosier Healthwise Package C members. Inpatient claims submitted to the IHCP that group to nonexperimental organ transplant DRGs are denied. DRGs for nonexperimental organ transplants are 103, 302, 480, 481, 765, 803, 804, and 805.

• Inpatient care rendered in an institution for mental diseases (IMD) having more than 16 beds is not covered for Hoosier Healthwise Package C members. This restriction does not apply to acute care hospitals that are not IMDs. The following providers systematically bypass this edit:
  – Four County Counseling Center
  – Grant-Blackford Mental Health – Grant County
  – Hamilton Center, Inc.
  – Oaklawn Psychiatric Center – Elkhart County
  – Otis R. Bowen Center – Kosciusko County
  – Park Center – Allen County
  – Southlake Center for Mental Health – Lake County
  – Wabash Valley Hospital

Long-Term Acute Care Reimbursement

An IHCP Long-Term Acute Care (LTAC) hospital is a freestanding general acute care hospital licensed under IC 16-21, meeting the following criteria:

• Is designated by the Medicare program as a long-term hospital

• Has an average inpatient length of stay greater than 25 days, based on the same criteria used by the Medicare program to determine whether a hospital’s average length of stay is greater than 25 days

Hospitals meeting the definition of an LTAC hospital are paid a daily rate, or per diem, for each day of care provided. The per diem is all-inclusive. No other payments are permitted in addition to the LTAC per diem.

Qualifying providers must be enrolled as an IHCP LTAC hospital to receive the LTAC Level of Care per diem.

Prior authorization (PA) is required for all LTAC admissions.

The rates for existing LTAC providers are adjusted no more often than every second year, based on the prior state fiscal year’s (SFY’s) claims data and are effective for claims incurred beginning the following January 1. For example, claims incurred during SFY 2009 (July 1, 2008, to June 30, 2009) are used to calculate a rate that is effective for all of calendar year 2010.

The OMPP conducts eligibility reviews once each year as part of the annual LTAC rate-setting initiative.

New LTAC hospitals receive the statewide median rate until sufficient claims are available to calculate a facility-specific rate. It is the provider’s responsibility to request a facility-specific rate after sufficient discharges are submitted. When calculated, the facility-specific rate is retroactively effective
upon the date of the provider’s request for a revised rate, unless sufficient discharges are still not available at the time of the request. In this case, a rate becomes effective on the date the provider reaches the rate-setting claims volume threshold.

Claims for as few as three discharges may be used to establish a per diem rate if the standard deviation of the rate is $200 or less. Otherwise, a higher discharge threshold of eight or more discharges must be used. If a provider has an existing rate, but does not meet the claims threshold or the standard deviation exception, the provider’s current per diem rate applies the following year.

**Medicare Exhaust Claims**

**Benefits Exhausted Prior to Inpatient Admission**

The IHCP reimburses acute care hospitals for dually eligible (Medicare and Medicaid) IHCP members who exhaust their inpatient hospital Medicare Part A benefits prior to admission to acute care hospitals.

When a Medicare Part A stay is exhausted by Medicare prior to admission, providers must bill the date of admission through the date of discharge on the UB-04 claim form. **Do not bill the IHCP for partial inpatient stays.** The Medicare Remittance Notification (MRN) must be submitted with the claim to show benefits were exhausted prior to the date of admission.

Providers must bill services payable to Medicare Part B before billing the exhaust claim to Medicaid. Because these claims are considered Medicaid primary claims, all IHCP filing limit and prior authorization rules apply. Refer to **IHCP Provider Manual Chapter 10** for information about waiving filing limit procedures and supplying appropriate documentation for claim adjudication. The **IHCP Provider Manual** is available on the Manuals page of the IHCP Web site at [http://www.indianamedicaid.com](http://www.indianamedicaid.com).

**Benefits Exhausted During an Inpatient Stay**

When a dually eligible member exhausts Medicare Part A benefits during an inpatient stay, the claim automatically crosses over from Medicare and adjudicates according to the IHCP inpatient crossover reimbursement methodology. Once the coinsurance and deductible amounts are considered, no additional payment will be made on the claim. This is also true for claims that do not automatically cross over but are submitted via the Web or paper.

The IHCP will continue to reimburse Medicare Part B charges, as long as the revenue codes billed on the Medicare Part A and B claims are not the same. If the same revenue codes appear on both claims, the claim will deny for duplicate billing.

**Submitted Charges and Medicaid Allowed Amount**

Providers are reimbursed the lower of their submitted charges or the Medicaid allowed amount for all hospital services.
Section 3: Hospital Outpatient Services

General Information

Outpatient pricing calculates a flat rate for emergency department treatment rooms, nonemergency department treatment rooms, and ambulatory surgical centers (ASCs). Additionally, certain services are billed as add-ons and others are billed separately. These services must be submitted on the UB-04 claim form for all claims received as of March 1, 2008. Paper claims submitted on the UB-92 claim form as of March 1, 2008, are not processed and are returned to the provider.

The following are the four categories of service in the outpatient reimbursement system:

- Outpatient surgeries
- Treatment room visits and emergency versus nonemergency visits
- Stand-alone services, including radiology and laboratory services
- Add-on services

Outpatient Surgeries

Outpatient surgeries are reimbursed at a flat fee that includes reimbursement for related procedures in an all-inclusive rate. The outpatient surgery reimbursement methodology was designed using the Medicare-established ASC methodology. Surgical procedure codes are classified into one of several reimbursement categories with specific reimbursement rates established for each category. All services are included in the all-inclusive reimbursement rate.

Providers can obtain rate information by contacting HP Customer Assistance.

The Indiana Health Coverage Programs (IHCP) Web site includes ASC assignment codes and pricing. The ASC assignment codes classify Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes to a payment group based on an estimate of the facility costs associated with performing the procedures. Providers may access this information on the IHCP Web site at www.indianamedicaid.com under Fee Schedule. The ASC listing contains assignment codes, effective dates, and pricing. Additionally, assignment codes relating to specific CPT and HCPCS codes are available on the IHCP Web site under Fee Schedule using the procedure code or description search feature.

The maximum IHCP reimbursement for each surgical procedure is two units of service to accommodate bilateral procedures. One unit is paid at 100 percent of the ASC rate, and the second unit is reimbursed at 50 percent of the ASC rate. Additional units are denied:

- When multiple surgical procedures are performed within the same incision, the IHCP pays the procedure with the highest ASC rate at 100 percent of that rate.
- Secondary procedures, not performed at the same incision site are reimbursed at 50 percent of the respective ASC rates.

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Bilateral procedures are reimbursed at 150 percent of the allowed amount. The reimbursement methodology also subjects multiple procedures performed within different incisions or operative fields to this same logic. For example, if two different surgical procedures are performed in two different incision or operative fields, the procedure with the highest ASC rate is reimbursed at 100 percent of that rate, and the second procedure is reimbursed at 50 percent of the ASC rate for that procedure. A maximum of two separate surgical procedures is reimbursable.

**Outpatient Reimbursement for Drug-Eluting Stents**

Outpatient reimbursement for drug-eluting stents and all associated facility charges is made using revenue codes 36X or 49X in combination with HCPCS codes G0290 – Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel, and G0291 – Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel.

No additional payment is made for the stent when the patient is in an inpatient hospital setting.

**Treatment Room Visits**

Treatment room reimbursement is limited to one unit per day, per member, per provider.

**Fee-for-Service**

Under the fee-for-service (FFS) reimbursement methodology, hospital emergency and nonemergency treatment room visits are reimbursed at the same statewide flat rate, which includes most drugs and supplies.

**Risk-Based Managed Care**

Members enrolled in a Hoosier Healthwise managed care organization (MCO) can seek care without authorization for an emergency medical condition, subject to the prudent layperson standard IC 12-15-12-0.3, from providers not contracted with the MCO.

For emergency department claims that do not include an emergency diagnosis or MCO authorization, state and federal requirements provide that the MCO shall review the medical record to determine whether the member presented with an emergency medical condition, subject to the prudent layperson standard. If the review results in a determination that the prudent layperson standard was not met, the claim may be denied.

**Stand-alone Services**

Stand-alone services, such as dialysis and physical, occupational, and speech therapies are reimbursable at an established flat statewide rate. A maximum of one unit of service per revenue code for each date of service is allowed.

Laboratory and radiology services are reimbursed at the lower of the submitted charge on the claim or the fee schedule amount. Multiple units of laboratory and radiology services are available for reimbursement.
Add-On Services

Certain add-on services may be paid if billed in conjunction with a treatment room, emergency department setting, or a stand-alone service. Add-on services are reimbursed at a flat statewide rate.

Outpatient Billing

Amendments to 405 IAC 1-8-2, 405 IAC 1-8-3, 405 IAC 1-10.5-2, and 405 IAC 1-10.5-3 required several billing and reimbursement changes effective November 1, 2004.

Outpatient Service within Three Days of an Inpatient Stay

See Section 2: Hospital Inpatient Services for more information.

Outpatient Service within Three Days of a 24-Hour Inpatient Stay

See Section 2: Hospital Inpatient Services for more information.

Inpatient Stays Less than 24-Hours

See Section 2: Hospital Inpatient Services for more information.

Submitted Charges and Medicaid-Allowed Amount

Providers are reimbursed the lower of their submitted charges or the Medicaid-allowed amount for all hospital services.
Section 4: Physician, Limited License Practitioner, and Other Nonphysician Practitioners

General Information

Physicians, limited license practitioners, and other nonphysician medical practitioners that bill 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 risk-based managed care (RBMC) plan, practitioners are reimbursed at the lower of the submitted charge or the established statewide RBRVS fee schedule allowance for the procedure. The RBRVS fee is based on the Medicare relative value unit multiplied by the conversion factor for the procedure as established by the Office of Medicaid Policy and Planning (OMPP).

Note: The Indiana Health Coverage Programs (IHCP) Fee Schedule is located on the IHCP Web site at www.indianamedicaid.com and can be downloaded free of charge. The fee schedule is automatically updated each month or as needed.

To obtain a paper copy of the IHCP Fee Schedule, send a check made payable to HP in the amount of $43 to the following address:

HP Written Correspondence
P. O. Box 7263
Indianapolis, IN  46207-7263

The IHCP Fee Schedule contains a complete list of Current Procedural Terminology (CPT®) 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 RBRVS reimbursement methodology is used in the IHCP Fee Schedule for physician services. 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.

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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 RBRVS 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 – 0.980
- Practice expense – 0.905
- Malpractice expense – 0.516

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

\[
\text{Total Base RVUs} = (\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice RVU} \times \text{Practice GPCI}) + 
(\text{Malpractice RVU} \times \text{Malpractice GPCI})
\]

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

\[
\text{Total Base RVUs} \times \text{RBRVS Conversion Factor}
\]

Services are reimbursed using the RBRVS 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 Fee Schedule.
- Relative value units 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 Fee
Schedule are reimbursed using the RBRVS 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 Fee Schedule that do not have
RVUs to be used with the RBRVS methodology are reimbursed by IHCP based on a maximum fee
schedule or manual pricing methodology. RVUs are not available for some procedures on the
Medicare Fee Schedule because the procedure is:
- Carrier-priced
- Excluded from the Medicare 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 the 26 modifier, have RVUs and are priced using the RBRVS IHCP Fee Schedule. All other laboratory procedures are reimbursed according to the Medicare Clinical Laboratory Fee Schedule.

Radiological procedures with RVUs on the Medicare Fee Schedule are reimbursed using the RBRVS IHCP Fee Schedule. Radiological procedures that do not have an RVU are reimbursed by the IHCP based on a maximum fee schedule or manual pricing methodology.

Other procedures excluded from the RBRVS reimbursement methodology include anesthesiology services. The IHCP reimburses for anesthesiology services according to a statewide fee schedule calculated 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 OMPP.

Providers can request the current RBRVS conversion factor by contacting HP Customer Assistance at (317) 655-3240 in the Indianapolis area or toll-free at 1-800-577-1278. Providers can download the IHCP Fee Schedule from the IHCP Web site at www.indianamedicaid.com.

Special Payment Situations

Under RBRVS pricing, certain situations exist resulting in special payment provisions within the IHCP Fee Schedule.

Modifiers Affecting Payment

In addition to the payment differential for nonphysician practitioners, the RBRVS payment methodology includes the use of certain pricing modifiers and other policies that have an impact on the payment amount as follows:

- **Assistant Surgeon Modifier** – Providers that bill as surgical assistants must use modifiers 80, 81, or 82. Payment is made at 20 percent of the RBRVS IHCP Fee Schedule amount. IHCP Fee Schedules are available on the IHCP Web site.

  **Note:** Providers billing for physician assistants should use the AS modifier. For more information about billing for a physician assistant, see Chapter 8, Section 3: CMS-1500 Billing Instructions, Mid-Level Practitioner Services.

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

- **Preoperative and Intraoperative Services** – 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 RBRVS IHCP Fee Schedule amount for the surgical procedure code. Adding modifier 54 – *Surgical Care Only* to the procedure code on the CMS-1500 claim form, identifies when one physician performs a surgical procedure and another physician provides preoperative and postoperative management of surgical services.

- **Postoperative Services** – Providers that perform postoperative services, but did not perform the surgery, must bill using modifier 55 – *Postoperative Management*. Providers are reimbursed a percentage of the RBRVS IHCP Fee Schedule amount. The percentage adjustment for modifiers 54 and 55 is specific to the surgical procedure.
Chapter 8 provides additional information about modifiers.

**Payment Differentials for Nonphysician Practitioners**

Reimbursement for the following provider types under the RBRVS IHCP Fee Schedule is based on less than 100 percent of the physician fee schedule amount.

- Independently practicing advance practice nurses (enrolled as type 09, specialty 090-095)
- Independently practicing respiratory therapists
- Psychologists, other than health services 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 405 IAC 5-20-8
- Certified registered nurse anesthetists (CRNAs) (enrolled as type 09, specialty 094)
- Licensed marriage and family therapists, mental health counselors, and clinical nurse specialists
- Effective April 1, 2006, certain identified procedures can be performed by a certified physical therapists’ assistant. These services must be billed with modifier HM and will be reimbursed at 75 percent of the reimbursement for a PT.

The fee schedule is based on claims data from physicians and limited license practitioners. Nonphysician providers are reimbursed at 75 percent of the physician fee to reflect differences in education and training. Certified registered nurse anesthetists are reimbursed at 60 percent of the physician fee allowance. Providers must submit claims with the appropriate modifier for the system to apply the correct reduction.

The IHCP Fee Schedule is available on the IHCP Web site at www.indianamedicaid.com. The fee schedule is automatically updated each month or as needed.

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

Enrolled nonphysician practitioners, including advanced practice nurses associated with a group, must use the unique, individual National Provider Identifier (NPI) number when billing. Nonphysician practitioners without individual NPI numbers must use the supervising physician’s NPI number in field 24J – bottom portion on the CMS-1500 claim form, along with the appropriate modifier. The group provider NPI number is entered as the billing provider NPI number in field 33a.

**Multiple Surgeries**

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:

- 100 percent of the global fee for the most expensive procedure
- 50 percent of the global fee for the second most expensive procedure
- 25 percent of the global fee for the remaining procedures
Site of Service Adjustment

Providers that perform procedures in an outpatient setting or place of service 22, 23, or 62, which are normally provided in a physician’s office, are subject to a site of service payment adjustment that is 80 percent of the practice expense component of the statewide RBRVS IHCP Fee Schedule. These procedures are identified with a site of service indicator on the Medicare Fee Schedule database.
Section 5: Long-Term Care Facility Services

General Information

There are two reimbursement methodologies for long-term care (LTC) facilities based on the type of facility rendering the service. This section outlines the reimbursement methodologies for nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR). Reimbursement of LTC facility services is not available for Hoosier Healthwise Package C members.

Nursing Facility Services

Case Mix Reimbursement

The Indiana Health Coverage Programs (IHCP) reimburses nursing facilities using a case mix methodology system. This system is based on the principle that payment for nursing facility services should take into account a resident’s clinical condition and the resources needed to provide appropriate care for that condition. Therefore, the case mix system of reimbursement is based on one IHCP rate, adjusted each quarter for changes in a patient’s acuity level, for all IHCP residents in an IHCP-certified or dually licensed nursing facility.

The case mix system of reimbursement allocates greater IHCP payment to direct patient care, while continually responding to cost changes that occur with respect to the resources used in providing that care.

Under the case mix reimbursement system, the IHCP rate is the sum of the following separate rate components:

- Direct care – Direct care includes the following:
  - All allowable nursing and nursing aide services
  - Medical supplies
  - Medical director services
  - Medical record costs
  - Nurse aide training
  - Nurse consulting services
  - Oxygen
  - Pharmacy consultants

- Indirect care – Indirect care includes the following:
  - Activity services and supplies
  - Allowable dietary services and supplies
  - Patient housekeeping services and supplies
  - Patient laundry services and supplies
  - Plant operations services and supplies
  - Raw food
Social services and supplies
Utilities
Repairs and maintenance
Recreational services and supplies

• Administrative – Administrative includes the following:
  - Allowable advertising
  - Allowable administrator and co-administrator services
  - Allowable home office services and supplies that are patient-related and appropriately allocated to the nursing facility
  - Legal and accounting fees
  - Liability insurance
  - License dues and subscriptions
  - Management
  - Office and clerical staff
  - Office supplies
  - Other consultant fees
  - Owners’ compensation (including director’s fees) for patient-related services
  - State gross receipts taxes
  - Telephone
  - Travel
  - Utilization review costs
  - Working capital interest
  - Qualified Mental Retardation Professional (QMRP)

• Capital – Allowable capital-related items include the following:
  - Fair rental value allowance
  - Property insurance
  - Property taxes

• Therapy – Direct cost for allowable therapy services

• Report Card Score Add-On – Based on a nursing facility’s report card score using the latest published data as of the end of each state fiscal year. Facilities that did not have a report card score published as of the recently completed state fiscal year may receive a rate add-on equal to $2.

• Special Care Unit Add-on – Nursing facilities that provide specialized care to residents with Alzheimer’s disease or dementia, and operate a special care unit (SCU) for such residents as demonstrated by resident assessment data as of March 31 of each year, are eligible for a special care unit add-on.

• Ventilator Unit Add-On – Nursing facilities that provide inpatient services to more than eight ventilator-dependent residents may receive additional reimbursement at a rate of $11.50 per Medicaid resident day.
• Quality Assessment Fee Add-On – The add-on is determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk reviewed annual financial report.

The OMPP retains a contractor that establishes the applicable rate.

Quality Assessment Fee

Nursing facilities are required to pay a quality assessment fee in the following amounts:

• $10 per non-Medicare (for example, private pay and Medicaid) patient day if the nursing facility’s total census is fewer than 70,000 patient days per year.

• $2.50 per non-Medicare (for example, private pay and Medicaid) patient day if the nursing facility’s total census is at least 70,000 patient days per year or the nursing facility is nonstate government owned or operated.

• Additionally, if a nursing facility is hospital based, a Continuing Care Retirement Center (CCRC) or the Indiana Veterans’ Home, no assessment fee applies.

Leave Days

Although it is not mandatory for facilities to reserve beds, the IHCP reimburses for reserved beds for members at one-half the per diem rate when the facility occupancy rate is 90 percent or above, provided that the criteria in 405 IAC 5-31-8 is met. The criteria are as follows:

• Hospitalization – Hospitalization must be ordered by a physician for treatment of an acute condition that cannot be treated in the nursing facility. The total length of time allowed for payment of a reserved bed for a single hospital stay is 15 consecutive days. When the 15-day bed-hold period has expired, the resident is no longer required to be discharged.
  – Hospital bed-hold days must be billed using revenue code 185 or 180, based on the facility’s occupancy percentage. Providers must use revenue code 185 to denote a leave of absence for hospitalization when the occupancy rate is 90 percent or above. Revenue code 180 is to be billed for nonpaid leave days when the occupancy rate is below 90 percent.

• Therapeutic leave of absence – A leave of absence must be for therapeutic reasons, as prescribed by the attending physician and indicated in the member’s plan of care. The total length of time allotted for therapeutic leave in any calendar year is 30 days. The leave days need not be consecutive.
  – Therapeutic leave of absence days must be billed using revenue code 183 or 180, based on the facility’s occupancy percentage. Providers must use revenue code 183 to denote a therapeutic leave of absence when the occupancy rate is 90 percent or above. Revenue code 180 is to be billed for nonpaid therapeutic leave days when the occupancy rate is below 90 percent.

Leave days cannot be billed for the day of discharge or the day of readmission to the facility, nor can they be billed when the resident’s return is not anticipated.

Note: Although nursing facilities are not entitled to reimbursement for leave days when census is less than 90 percent occupancy, these days must be billed using revenue code 180.
Intermediate Care Facilities for the Mentally Retarded Services

ICFs/MR are divided into three distinct categories:

- Large private ICF/MR – More than eight beds
- Small ICF/MR – Four to eight beds and are commonly referred to as community residential facilities for the developmentally disabled (CRF/DD)
  - Basic developmental
  - Child rearing
  - Child-rearing residences with specialized programs
  - Developmental training
  - Intensive training
  - Sheltered living
  - Small behavioral management residences for children
  - Small extensive medical needs residences for adults
  - Extensive support needs residences for adults
- State-operated facilities – More than eight beds

Proprietary Large Private and Small ICFs/MR

The all-inclusive per diem rate for these facilities includes the following services:

- Durable medical equipment (DME) – All DME, except customized items and associated repair costs, including but not limited to the following:
  - Ice bags
  - Bed rails
  - Canes
  - Walkers
  - Crutches
  - Standard wheelchairs
  - Traction equipment

Customized equipment includes any piece of equipment designed for a particular member that cannot be used by other members. The equipment contains parts that are specially made and not readily available from a DME provider.

- Medical and nonmedical supplies – All medical and nonmedical supplies and equipment including those items generally required to ensure adequate medical care and personal hygiene of residents. The facility, pharmacy, or other provider may not bill these items to the IHCP separately.
- Mental health services – Including behavior management services and consulting, psychiatric services, and psychological services.
- Nursing care – Nursing services and supervision of health services.
- Room and board – Room accommodations, all dietary services (including routine and special dietary services and school lunches), and personal laundry services.
Therapy services – Physical and occupational therapy, speech pathology, and audiology services provided by a licensed, registered, or certified therapist, as applicable, employed by the facility or under contract with the facility are included in the all-inclusive rate. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. All therapies must be specific and effective treatment for the improvement of function. Reimbursement is not available for services for remediation of learning disabilities.

Transportation – The reasonable cost of necessary transportation for the recipient is included in the per diem rate, including transportation to vocational/habilitation services, except for transportation that is provided to accommodate the delivery of emergency services. Emergency transportation services must be billed to Medicaid directly by the transportation provider.

Habilitation – Habilitation services provided in a family and social services administration approved setting that are required by the resident’s program plan of active treatment developed in accordance with 42 CFR 483.440, including, but not limited to, the following:

- (A) Training in activities of daily living
- (B) Training in the development of self-help and social skills
- (C) Development of program and evaluation plans
- (D) Development and execution of activity schedules
- (E) Vocational/habilitation services

Note: The all-inclusive per diem rate for small ICFs/MR also includes day habilitation services.

State-Operated Intermediate Care Facilities for the Mentally Retarded

The cost of the following services is included in the all-inclusive per diem rate for these facilities:

Dental services – Dental services provided in the facility shall be included in the per diem rate. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization by the performing dental provider office. Dental services prior authorized by the dental provider office must be billed to the Medicaid program directly by the dental provider. Admission of a recipient to a hospital for the purpose of performing dental services requires prior authorization by the performing dental provider office.

DME/HME – All DME/home medical equipment (HME) except customized items and associated repair costs, including but not limited to the following:

- Ice bags
- Bed rails
- Canes
- Walkers
- Crutches
- Standard wheelchairs
- Traction equipment

Customized equipment includes any piece of equipment designed for a particular member that cannot be used by other members. The equipment contains parts that are specially made and not readily available from a DME/HME provider.
• Medical and nonmedical supplies – All medical and nonmedical supplies and equipment including those items generally required to ensure adequate medical care and personal hygiene of residents.
• Medical services – Including preventive and general medical care as well as annual physical examinations of each client.
• Mental health services – Including behavior management services and consulting, psychiatric services, and psychological services.
• Optometry services – Evaluation of vision.
• Pharmaceutical products – Including the provision or arrangement for the provision of routine and emergency drugs and biologicals for the members.
• Room and board – Room accommodations, all dietary services (including routine and special dietary services and school lunches), and laundry services.
• Therapy services – Medically necessary and reasonable therapy services, including physical therapy, occupational therapy, speech therapy, respiratory therapy, and audiological services.
• Transportation – Transportation services, except for emergency medical transportation services, are covered in the per diem rate. Transportation for emergency medical services must be billed to Medicaid directly by the transportation provider.
• Vocational and habilitation services – Vocational and habilitation services provided in a Family and Social Services Administration (FSSA)-approved setting that are required by the resident’s program plan of active treatment.

**Leave Days**

Reimbursement is available for reserving beds for members in a private or State-operated ICF/MR, provided that the criteria set out in 405 IAC 5-13-6 is met.

Providers must use the appropriate room and board revenue code for the days the member was a patient in the ICF/MR and use the applicable leave of absence revenue code for the days the member was out of the ICF/MR.

The two types of reimbursed leave days are as follows:

• Hospitalization – Must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total time allowed for payment of a reserved bed for a single hospital stay is 15 consecutive days. If the member requires hospitalization longer than 15 consecutive days, the member must be discharged from the ICF/MR. If the member is discharged from the ICF/MR following a hospitalization in excess of 15 consecutive days, the ICF/MR is still responsible for appropriate discharge planning. Discharge planning is required if the ICF/MR does not intend to provide ongoing services following the hospitalization for those members who continue to require ICF/MR Level of Care services. The facility must maintain a physician’s order for hospitalization in the member’s file at the facility. **Providers must use revenue code 185 to denote a leave of absence for hospitalization.**

• Therapeutic leave of absence – Must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the member’s habilitation plan. The maximum total length of time allotted for therapeutic leaves in any calendar year is 60 days per member residing in an ICF/MR. The leave days need not be consecutive. If the member is absent for more than 60 days per year, no further reimbursement is available to reserve a bed for that member in that year. The facility must maintain a physician’s order for the therapeutic leave in the member’s file at the facility. **Providers must use revenue code 183 to denote a therapeutic leave of absence.**

Use Revenue code 180 when the hold days are not eligible for payment.
**Tax Assessment**

Large and small private ICFs/MR are assessed a percentage of the annual gross residential services revenue of the facility for the facility’s preceding fiscal year. The assessment on provider gross residential services revenue is an allowable cost for cost reporting and audit purposes. Gross residential services revenue is revenue from the provider’s previous annual reporting period.
Section 6: Home Health Services

General Information

Pursuant to 405 IAC 1-4.2, home health providers are reimbursed for covered and prior authorized services provided to Indiana Health Coverage Programs (IHCP) members through standard, statewide rates computed by adding the following:

- Overhead cost rate
- Staffing cost rate multiplied by the number of hours spent performing billable patient care activities
- As of July 1, 2008, reimbursement is limited to one overhead per day using occurrence code 61. Occurrence codes 62 through 66 are not valid for dates of service beginning July 1, 2008, and forward.

Additional information about home health billing is located in Chapter 8.

Providers can obtain the current wage rate from HP Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278. Providers can also visit www.indianamedicaid.com, click Bulletin List, and search by keyword “home health” for the most current publication containing home health rates.
Section 7: Hospice Services

General Information

Reimbursement for the Indiana Health Coverage Programs (IHCP) hospice benefit follows the methodology and amounts established by the Centers for Medicare & Medicaid Services (CMS) for administration of the federal Medicare Program. Services are reimbursed at one of four all-inclusive per diem rates for each day in which a member is in hospice care. The rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare premium amounts. The rates are further adjusted for regional differences in wages, using indices published by CMS. This section provides information about the reimbursable levels of service.

Routine Home Hospice Care Delivered in a Private Home

The IHCP reimburses the hospice provider at the routine home care rate for each day the member is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services on any given day.

Routine Home Hospice Care Delivered in a Nursing Facility

The IHCP reimburses the hospice provider at the routine home care rate for each day the member is in a nursing facility, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services on any given day. In addition, the hospice provider is paid an additional room and board per diem at 95 percent of the lowest nursing facility rate to cover costs incurred by the contracted nursing facility. The additional room and board per diem is 95 percent of the single nursing facility case mix rate.

Continuous Home Hospice Care Delivered in a Private Home

Continuous home care is provided only during a period of crisis. A period of crisis occurs when a patient requires continuous care, primarily nursing care, to achieve palliation and management of acute medical symptoms. A minimum of eight hours of care must be provided during a 24-hour day that begins and ends at midnight. A registered nurse or a licensed practical nurse must provide care for more than half the total period of care. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the member to remain at home, this is covered as routine home care. The continuous home care rate is divided by 24 hours to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate is reimbursed to the hospice provider for up to 24 hours a day.

Continuous Home Hospice Care Delivered in a Nursing Facility

As in the private home setting, the continuous home care rate is divided by 24 hours to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate is reimbursed to the hospice provider up to 24 hours a day. All the limitations listed for the private home setting also apply in the nursing facility setting. In addition, the hospice provider is paid an additional room and board per diem at 95 percent of the lowest nursing facility rate to cover costs incurred by the
contracted nursing facility. The additional room and board *per diem* shall be 95 percent of the single nursing facility case mix rate.

### Inpatient Respite Hospice Care

The IHCP reimburses the hospice provider at the inpatient respite care rate for each day the member is in an approved inpatient facility and is receiving respite care. Respite care is short-term inpatient care provided to the member only when necessary to relieve family members or others caring for the member. Respite care can be provided only on an occasional basis. Payment for respite care can be made for a maximum of five consecutive days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is made at the routine home care rate. This service applies only to members who normally reside in private homes.

### Hospice Care in Group Homes

Medicaid-eligible group home members can elect the Medicaid hospice program per the CMS. The hospice should bill Medicaid for the hospice services and the group home can bill Medicaid directly for the group home *per diem* rate. Hospice and group home providers should coordinate the overall care for the group home member. It is the responsibility of the hospice to provide all hospice-covered services in frequency and scope to care for the terminal illness and related conditions. Furthermore, the hospice should not delegate any hospice core services to group home staff. Any questions about the Medicaid hospice program should be directed to the Family and Social Services Administration (FSSA) Division of Aging program director at (317) 233-1956 or 1-888-673-0002.

### General Inpatient Hospice Care

The IHCP reimburses the hospice provider at the general inpatient hospice care rate for each day the member is in an approved inpatient hospice facility and is receiving general inpatient hospice care for pain control or acute or chronic symptom management related to the terminal illness that cannot be managed in other settings.

For inpatient respite and general inpatient stays, the day of discharge is not paid unless it is the date of death.

### Emergency Hospice Services

If emergency services are related to the terminal illness and the hospice member has not revoked the hospice benefit, the hospice provider is responsible for hospital and transportation charges associated with all emergency services provided.

If the emergency services are unrelated to the terminal illness, the IHCP may reimburse the transportation and hospital claims associated with the emergency services.

**Note:** Members enrolled in Care Select or risk-based managed care (RBMC) must disenroll before authorization for hospice benefits can be completed.
Section 8: Laboratory Services

General Information

Most clinical diagnostic laboratory procedures performed in a physician’s office by an independent laboratory or by a hospital laboratory for its outpatients, are reimbursed on the basis of the lower of the submitted charge, the Medicare Clinical Lab Fee Schedule, or the resource-based relative value scale (RBRVS) Indiana Health Coverage Programs (IHCP) Fee Schedule. The IHCP Fee Schedule is available on the IHCP Web site at www.indianamedicaid.com. The fee schedule is automatically updated each month or as needed. The IHCP reimburses procedures on the Medicare Fee Schedule that do not have relative value units (RVUs). This reimbursement is based on the Medicare Clinical Laboratory Fee Schedule or manual pricing methodology if a rate has not yet been established by Medicare.

Under Clinical Laboratory Improvement Amendment (CLIA) regulations, providers must have a valid CLIA number on file with the IHCP to be reimbursed for any clinical laboratory services.

Note: Regulations require that the laboratory analyzing the specimen submit the charge to the IHCP. It is not appropriate for a physician to bill using modifier 90 for a laboratory service that was analyzed by an outside laboratory.

Chapter 8 provides more information about billing laboratory services.

Physician Interpretation of Laboratory Procedures

The IHCP reimburses for the Current Procedural Terminology (CPT®) clinical lab codes shown in Table 7.1, which allow interpretation. The IHCP follows Medicare guidelines for the CPT clinical lab codes that allow interpretation.

Table 7.1 – Clinical Lab Codes that Allow Interpretation

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Providers report the technical and professional components separately to ensure proper reimbursement. Providers bill the IHCP for the technical component of the clinical lab procedure reporting the base code only, without modifier TC. If providers bill the modifier TC at the claim detail, the IHCP must deny the claim. Providers should report the interpretation service with the CPT code and modifier 26. For example, providers performing the technical component and interpretation of CPT code 84165, report CPT code 84165 for the technical component and report the CPT code modifier combination 84165-26 for the interpretation.
Questions about this information may be directed to HP Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.
Section 9: Pharmacy Services

General Information

The information contained in this section applies to all Indiana Health Coverage Programs (IHCP) members.

Pharmacy reimbursement consists of the following components:

- Legend drugs
- Nonlegend drugs (over-the-counter [OTC] drugs)
- Dispensing fee
- Drug copayment

Legend Drugs

A pharmacy is entitled to reimbursement for covered legend drugs at the lowest of the following:

- The product’s estimated acquisition cost (EAC), multiplied by the units billed as of the dispense date, plus an IHCP dispensing fee of as much as $4.90, if applicable
  - EAC is defined as the average wholesale price (AWP) of the billed item, less 16 percent for brand products or AWP less 20 percent for generic products. AWP data is provided by the drug database vendor to the fiscal agent weekly.
- The product’s State maximum allowable cost (State MAC), if applicable, multiplied by the units billed as of the dispense date, plus an IHCP dispensing fee of as much as $4.90, if applicable
- The provider’s submitted charge, which should represent the usual and customary charge for the product to the general public as of the dispense date

Note: In accordance with the Indiana Administrative Code (IAC) in 405 IAC 5-24-6 (b), a pharmacy provider is entitled to a maximum of one dispensing fee per legend drug order, per member, per month, for members residing in an IHCP-certified long-term care facility.
Nonlegend Drugs (Over-the-Counter Drugs)

Note: OTC drugs, except for insulin, are not covered for Hoosier Healthwise Package C members.

Only those nonlegend drugs included on the Preferred Drug List (PDL) and nonlegend insulin are covered for Healthy Indiana Plan (HIP) members.

A pharmacy is entitled to reimbursement for covered nonlegend drugs included on the OTC Drug Formulary at the lower of the following:

- The State OTC maximum allowable cost (MAC) of the product multiplied by the units billed, as of the dispense date, multiplied by 150 percent; or
- The provider’s usual and customary charge for the product to the general public, as of the dispense date.

Note: For residents of long-term care facilities, covered OTC drugs are to be billed to the IHCP by only pharmacy providers. Covered OTC drugs are not reimbursable to long-term care facilities, and the facilities are not to bill covered OTC drugs to the IHCP.

The IHCP allows a dispensing fee up to a maximum of $4.90 per legend drug, as specified by 405 IAC 5-24-6. Pharmacy providers are required to bill the provider’s usual and customary charge, which includes the provider’s dispensing fee, if any, when submitting claims for reimbursement.

Drug Copayment

The IHCP drug copayment is set out in Indiana Medicaid rule at 405 IAC 5-24-7, which at the time of publication of this manual is as follows:

405 IAC 5-24-7 Copayment for legend and nonlegend drugs

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2 Affected: IC 12-13-7-3; IC 12-15-6

Sec. 7. (a) Under IC 12-15-6, a copayment is required for legend and nonlegend drugs and insulin in accordance with the following:

(1) The copayment shall be paid by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the recipient is liable.

(2) In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual’s inability to pay the copayment amount. Under 42 CFR 447.15, this service guarantee does not apply to an individual who is able to pay, nor does an individual’s inability to pay eliminate his or her liability for the copayment.

(3) The amount of the copayment will be three dollars ($3) for each covered drug dispensed.

The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid.

(b) The following pharmacy services are exempt from the copayment requirement:
(1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care

(2) Services furnished to individuals less than eighteen (18) years of age

(3) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy

(4) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions

(5) Family planning services and supplies furnished to individuals of child bearing age

(6) Health maintenance organization (HMO) pharmacy services

Note: 42 CFR 447.15 mandates that a provider may not refuse to provide services to a recipient who cannot afford the copayment. IHCP policy is that the member remains liable to the provider for the copayment, and the provider may take action to collect it. The provider may bill the member for that amount and take action to collect the delinquent amount in the same manner that the provider collects delinquent amounts from private pay customers.

Providers may set office policies for delinquent payment of incurred expenses including copayments. The policy must apply to private pay patients as well as IHCP members. The policy should reflect that the provider will not continue serving a member who has not made a payment on past due bills for “X” months, has unpaid bills exceeding “Y” dollars, and has refused to arrange for or not complied with a plan to reimburse the expenses. Notification of the policy must be done in the same manner that notification is made to private pay customers.
General Information

Durable medical equipment (DME) and home medical equipment (HME) reimbursement is based on Medicare fee schedules and classifications of DME.

Several DME and HME service, equipment, and supply Healthcare Common Procedure Coding System (HCPCS) codes that are nonspecific code descriptions, such as unspecified, unclassified, and miscellaneous, are manually priced. An example of a manually priced HCPCS code is E1399 – Durable medical equipment, miscellaneous. Payment amount is based on individual consideration of the item:

- If the provider manufactures or customizes the item being billed, the provider submits a materials and labor itemization plus a manufacturer’s cost invoice with the claim. The IHCP reimburses the claim at 30 percent above the manufacturer’s cost to the provider.

- If the provider did not manufacture the item, the provider submits a retail invoice with the claim. The IHCP reimburses the provider at 90 percent of retail cost.

Most HCPCS codes specific to particular DME services, equipment, and supplies are reimbursed using the maximum fee pricing methodology.

Each year, as new codes are added, the Indiana Health Coverage Programs (IHCP) uses the current fee schedule for that year to establish pricing for the new codes.
Section 11: Dental Services

General Information

Dental services are reimbursed using a combination of a maximum fee pricing methodology and manual pricing methodology. Providers must bill dental services on the American Dental Association (ADA) 2006 Dental Claim Form using Current Dental Terminology (CDT) procedure codes. Only CDT procedure codes can be billed on the ADA 2006 dental claim form.

Risk-Based Managed Care Dental Services

Dental services billed on the ADA 2006 dental claim form using CDT procedure codes are a carved-out service, excluded from the responsibility of the risk-based managed care (RBMC) organization. Dental providers must submit dental claims incurred by RBMC members to HP for adjudication. However, when dental services are performed in an acute care setting for managed care organization (MCO) members, providers should submit these claims to the member’s MCO and follow the MCO’s criteria.
Section 12: Crossover Claims

General Information

The Indiana Health Coverage Programs (IHCP) reimburses covered services for Medicare crossover claims only when the Medicaid-allowed amount exceeds the amount paid by Medicare. In those instances where the Medicare-paid amount exceeds the Medicaid-allowed amount, claims are processed with a paid claim status with a zero reimbursed amount. If the Medicaid allowed amount exceeds the Medicare paid amount, the IHCP reimburses using the lesser of the coinsurance plus deductibles or the difference between the Medicaid-allowed amount and the Medicare-paid amount. The reimbursement also reflects any other third-party liability payments and spend-down deductible amounts. The following formulas represent how payment for crossover claims is calculated:

- Institutional crossover claims:
  
  \[(\text{Deductible} + \text{Coinsurance} + \text{Blood Deductible}) - (\text{Spend-down Deductible Amount} + \text{TPL Payments} + \text{Patient Liability [Nursing Homes Only]}) = \text{Reimbursement Amount}\]

- Physician crossover claims:
  
  \[(\text{Deductible} + \text{Coinsurance} + \text{Psychiatric Adjustment [when applicable]}) - (\text{Spend-down Deductible} + \text{TPL Payments}) = \text{Reimbursement Amount}\]

This information is for reimbursement methodology only. Chapter 8 and Chapter 10 provide information about paper and electronic crossover claim billing examples.
Section 13: Anesthesia

General information

The Administrative Simplification Requirements of the Health Insurance Portability and Accountability Act (HIPAA) mandate that covered entities adopt the standards for anesthesia Current Procedural Terminology (CPT®) codes. Providers billing anesthesia services must use anesthesia CPT codes 00100 through 01999. Anesthesia charges must be submitted using the anesthesia CPT code and a physical status modifier that corresponds to the surgical procedure performed. General, regional, or epidural anesthesia, administered by the same provider that performs the surgical or obstetrical delivery procedure, should not be billed using an anesthesia services code in addition to the procedure code. The surgical delivery fee includes anesthesia services. The IHCP used the relative values for 2002 as published by the American Society of Anesthesiologists.

Note: Providers must not report the base units on claims. IndianaAIM automatically determines base units for procedure codes submitted on the CMS-1500 claim form or the 837P electronic transaction.

Anesthesia CPT codes have 2002 relative value unit (RVU) and price according to Indiana Health Coverage Programs (IHCP) anesthesia methodology.

Anesthesia pricing calculation is as follows:

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

Additional reimbursement may be added to the rate if CPT codes for emergency (99140) or other qualifying circumstances are billed.

CPT Codes

CPT codes replace local code modifiers W6 and W7. CPT codes must be used with an AA modifier to denote they apply to anesthesia services. These must be billed as a separate line item of the claim form, and are reimbursed on a max fee basis.
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