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

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

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

Physicians and Limited License Practitioners

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

Non-Physician Practitioners

- audiologists,
- physical, occupational, respiratory, and speech therapists,
- licensed psychologists,
- independent laboratory or radiology providers,
- advance practice nurses,
- dentists who are not oral surgeons.
- board certified behavior analysts
- credentialed registered behavior technicians
- licensed pharmacists

Other Licensed or Certified Practitioners

- physician assistants,
- licensed independent practice school psychologist,
- licensed clinical social worker,
- licensed martial and family therapist,
- licensed mental health counselor,
- person holding a master’s degree in social work, marital and family therapy, or mental health counseling,
- licensed clinical addiction counselors
- certified registered nurse anesthetists, and
- anesthesiologist assistants
- community health workers

Other Licensed or Certified Practitioners are required to work under the direct supervision of a physician, except licensed clinical social workers, licensed marital and family therapists, licensed mental health counselors, and licensed clinical addiction counselors. Other Licensed Practitioners or Certified Practitioners, except physician assistants, certified registered nurse anesthetists, licensed clinical social workers, licensed marital and family therapists, licensed mental health counselors, and licensed clinical addiction counselors, must bill under the supervising physician's provider number. Except as otherwise noted in the plan, state-developed fee schedule rates for these services are the same for both governmental and private providers. All rates and effective dates are published on the agency’s website at in.gov/Medicaid.

Effective for services provided on or after February 1, 2015, the components of the RBRVS methodology used to develop the fee schedule include the July 2014 Medicare Physician Fee Schedule (MPFS) non-facility Relative Value Units (RVUs), the 2014 MPFS Geographic Practice Index (GPCI) for Indiana, and the 2014 MPFS conversion factor. The RVUs are adjusted using the following 20 14 Medicare locality GPCI values to reflect work, practice, and malpractice costs in Indiana: Work: 1.000, Practice Expense: 0.922, Malpractice: 0.615.

To determine the payment rate for each procedure under the RBRVS fee schedule, the Indiana-specific RVU for each procedure is multiplied by the conversion factor according to the following calculation: Payment Amount (Indiana RVU x Indiana Medicaid Conversion Factor). For services prior to February 1, 2015, the Indiana Medicaid conversion factor is $28.61, which was developed using Indiana Medicaid claims data from fiscal year 1992 and specific policy assumptions relative to the Indiana Medicaid program. Effective for services provided on or after February 1, 2015, the Indiana Medicaid conversion factor is $26.8671, which equals 75% of the 2014 MPFS conversion factor of $35.8228. These rates are published at the State's website, in.gov/Medicaid.

Effective for services provided on or after January 1, 2024, the components of the RBRVS methodology used to develop the Medicaid professional fee schedule include the Medicare Physician Fee Schedule (MPFS) non-facility Relative Value Units (RVUs), the MPFS Geographic Practice Index (GPCI) for Indiana, and the MPFS conversion factor published annually by the centers for Medicare and Medicaid Services (CMS). The Medicaid professional fee schedule will be reviewed annually, taking into account the MPFS non-facility RVUs, GPCIs for Indiana, and the conversion factor published by CMS that take effect January 1 of the calendar year preceding the Medicaid rate effective date and adjusted as necessary. For procedures without Medicare fee schedule values, reimbursement rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes. These rates are published at the State's website, in.gov/Medicaid.

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

The reimbursement rates for antepartum HCPCS codes 59425 and 59426 are the rates calculated as described above, divided by the expected number of visits. The expected number of visits is 5 for 59425 and 7 for 59426.1.

1. The reimbursement rates for anesthesiology procedures were developed using the total base and time units for each procedure multiplied by the Indiana Medicaid conversion factor for anesthesiology, $13.88. Effective for services provided on or after February 1, 2015, the Indiana Medicaid conversation factor for anesthesiology procedures will be $16.26, which is 75% of the 2014 Medicare anesthesiology conversion factor for Indiana of $21.68.

The calculation is: Anesthesia reimbursement rate (Base Units + Time Units +Additional Units for age (if applicable) + Additional Units for physical status modifiers (as applicable)) x anesthesia conversion factor. Base units were assigned to all anesthesia CPT codes (00100 through 01999) based on the 2002 relative values as published by the American Society of Anesthesiologists. Effective for services provided on or after February 1, 2015, base units for anesthesia CPT codes (001000 through 01999) are based on the 2014 Medicare anesthesia base units. Additional base units are added for age and physical status as applicable. A member younger than one year old or older than 70 years old will receive one (1.0) additional base unit. Physical status modifier P3 (severe systemic disease) receives one (1.0) additional base unit, P4 (severe systemic disease that is a constant threat to life) receives two (2.0) additional base units, and P5 (moribund patient not expected to survive without operation) receives three (3.0) additional base units. If CPT code 99140 is billed to denote an emergency, two (2.0) additional base units are added for physical status modifiers Pl through P5. No additional base units are added for physical status modifier P6.

Effective for services provided on or after January 1, 2024, the base and time units used for the Indiana anesthesiology fee schedule will be reviewed annually, taking into account the anesthesiology fee schedules published by CMS that take effect January 1 of the calendar year preceding the Medicaid rate effective date and adjusted as necessary. For procedures without Medicare fee schedule values, reimbursement rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes. All rates are published at the State's website, in.gov/Medicaid

Time units are converted from the actual time reported on the claim at the rate of one unit for each 15 minute period or fraction thereof. Anesthesia time begins when the anesthesiologist begins preparing the patient for anesthesia care and ends when the anesthesiologist is no longer in personal attendance.

Medical direction of two, three, or four anesthesia procedures is reported using modifier QK and is reimbursed at 30% of the allowable physician rate. Separate reimbursement is not available for anesthesia administered by the same provider performing the surgical procedure.

2. The fee schedule amounts for services of dentists in calendar year 1994 were developed based on fiscal year 1992 charges and the percentage difference between physician and LLP submitted charges for fiscal year 1992 and RBRVS fee schedule amounts. Effective August 1, 1995, to determine the Medicaid allowable amount for which the 1992 charges are not available, Medicaid sets reimbursement rates for most dental procedures equal to 100% of the 75th percentile of the rates reported by the American Dental Association for the East North Central Region (ADA-ENC). The ADA-ENC-based rates may be adjusted annually for inflation, using the Consumer Price Index — Urban, Dental (CPI-UD). The Medicaid agency may set reimbursement for specific dental procedures using a different methodology in order to preserve access to the service.

The five percent (5%) reduction in rates paid to providers in accordance with the methods described in Attachment 4.19-B for dental services provided on or after April 1, 2010 is extended through December 31, 2013.

Effective for services provided on or after January 1, 2024, reimbursement for services of dentists will be set at a percentile, or a percentage thereof, using a published survey of dental market data. All rates are published at the State's website, in.gov/Medicaid.

3. For telemedicine services provided through IATV technology, a facility fee for the originating site (where the patient is located at the time health care services through telemedicine are provided to the individual) is reimbursed at the lesser of the provider's billed charge or the maximum allowance established by the Office of Medicaid Policy and Planning. The reimbursement rate is paid for one unit per encounter. Effective for dates of service on or after January 1, 2024, the rate will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes.

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

The maximum allowance for reimbursement to the distant site (where the provider is located while providing health care services through telemedicine) is based on specific Evaluation and Management (E&M) and End Stage Renal Disease codes and paid as if a traditional encounter were performed.

Except as otherwise noted in the plan, state-developed fee schedule rates for telemedicine services are the same for both governmental and private providers. All rates are published at the State's website, in.gov/Medicaid.

4. Effective for services provided on or after July 1, 2021, the Medicaid allowed amount for COVID-19 monoclonal antibody infusion administration and COVID-19 vaccine administration will be equal to Indiana Medicare’s allowed amount for these services.

5. Effective for dates of service on or after July 1, 2021, EMT's under the directions of the physician will be reimbursed for appropriate and medically necessary medical care when an ambulance is dispatched, and treatment is provided to the patient without the patient being transported to another site. Reimbursement for treat-no-transport will be made for Healthcare Common Procedure Coding System (HCPCS) code A0998 at the Indiana Medicaid physician fee schedule rate for Current Procedural Terminology (CPT) code 99203.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for governmental and private physicians. All rates are published on the agency's website, at in.gov/Medicaid.

6. Beginning with dates of service on or after September 1, 2022, Medicaid will provide stand-alone general pediatric vaccination counseling as part of the early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Effective for dates of service on or after January 1, 2024, the rate will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes. All rates are published at the State's website, in.gov/Medicaid.

7. Effective for dates of service on or after January 1, 2024, the Medicaid reimbursement rates for applied behavior analysis (ABA) therapy are equal to the Indiana Medicaid Practitioner Fee Schedule rates in effect for that date of service. The Medicaid reimbursement rates are established by the Office based on provider cost information that includes direct care wages, fringe benefits, and non-wage related costs. Wage data from the U.S. Bureau of Labor Statistics is used to supplement provider wage data. Reimbursement rates will be reviewed every four years and adjusted as necessary by the office. For years not subject to a rate review a two percent rate adjustment will be made subject to budget approval.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ABA therapy services. The agency’s rates are published at the State’s website, in.gov/Medicaid.

II. Application of reimbursement methodology for services provided by physicians and limited license practitioners (LLPs)

1. Reimbursement for services provided by physicians, clinical and independently practicing psychologists, and limited license practitioners (LLPs), except for services described in subdivisions two (2) through six (6) below, will be equal to the lower of:

   ·the provider's submitted charges for the procedure, or
   ·the established Medicaid RBRVS physician fee schedule allowance for the procedure.

2. Services provided by assistant surgeons will be reimbursed at sixteen percent (16%) of the Medicaid RBRVS physician amount for the procedure and cosurgeons at sixty-two and one-half percent (62.5%) of the RBRVS fee schedule amount for the procedure. Assistant at surgery services provided by physician assistants and advanced practice registered nurses will be reimbursed at thirteen and six tenths percent (13.6%) of the Medicaid RBRVS physician amount for the procedure.

3. Reimbursement for all services is subject to the global surgery and multiple endoscopy policies as defined by the Centers for Medicare and Medicaid Services for the Medicare Part B fee schedule for physician services.

4. Reimbursement for services provided by physicians and LLPs is subject to the policy for supplies and services incident to other procedures as defined by the by the Centers for Medicare and Medicaid Services for the Medicare Part B fee schedule for physician services.

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

6. Reimbursement for services provided by physicians and LLPs is subject to the site-of-service payment adjustment. Procedures performed in a non-office setting that are normally provided in a physician's office will be subject to the facility practice expense relative value unit policy as defined by the Centers for Medicare and Medicaid Services for the Medicare Part B fee schedule for physician services.

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

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

1. Reimbursement for services provided by non-physician practitioners (NPPs), except services described below, will be equal to the lower of:
   ·the submitted charge for the procedure, or
   ·the established Medicaid RBRVS physician fee schedule amount for the procedure.
2. Outpatient mental health services provided by:
   a licensed psychologist will be reimbursed at seventy-five percent (75%) of the Medicaid RBRVS physician fee schedule amount for that procedure, and an advance practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing in a physician- directed outpatient mental health facility will be reimbursed at eighty-five percent (85%) of the Medicaid RBRVS physician fee schedule amount for that procedure.

3. Services provided on or after February 1, 2015 by independently practicing respiratory therapists (42 CFR 440.60), physical therapists' assistants (42 CFR 440.110) and advance practice nurses (42 CFR 440.166) will be reimbursed at seventy-five percent (75%) of the Medicaid RBRVS physician fee schedule amount for that procedure. Services provided on or after April 1, 2024 by advance practice nurses will be reimbursed at eighty-five percent (85%) of the Medicaid RBRVS physician fee schedule amount for that procedure. State developed fee schedule rates are the same for both public and private providers of these services.

4. Services provided for dates of service on or after July 1, 2018 by a certified community health worker and supervised by a physician, health services provider in psychology, advanced practice nurse, physician assistant, dentist, podiatrist, or chiropractor shall be reimbursed at fifty percent (50%) of the Medicaid RBRVS physician fee schedule amount for that procedure.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and privately employed providers. All rates are published at in.gov/Medicaid.

IV. Application of the RBRVS reimbursement methodology for services provided by other licensed practitioners

1. Certified registered nurse anesthetists (CRNAs) that are medically directed and anesthesiologist assistants (AAs) are reimbursed at 50% of the allowable physician rate. Certified registered nurse anesthetists (CRNAs) that are not medically directed are reimbursed at 100% of the allowable physician rate.

2. Physician assistants are reimbursed at 85% of the allowable physician rate.

3. Outpatient mental health services provided by:

   A licensed school psychologist, a licensed clinical social worker, a licensed marital and family therapist, a licensed mental health counselor, a licensed clinical addiction counselor, or a person holding a master's degree in social work, marital and family therapy, or mental health counseling in a physician-directed outpatient mental health facility will be reimbursed at seventy-five percent (75%) of the Medicaid RBRVS physician fee schedule amount for that procedure.

V. Laboratory services

For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement is based on the Medicare clinical laboratory fee schedule and is paid on a per test basis. The fee schedule rate for each laboratory procedure does not exceed the current Medicare fee schedule amount. Medicaid clinical diagnostic laboratory fee schedules comply with Section 1903(i)(7) that limits Medicaid payments for clinical diagnostic lab services to the amount paid by Medicare for those services on a per test basis. The Medicaid lab fee schedule will be reviewed annually, taking into account the Medicare lab fee schedule rates published by CMS that take effect January 1 of each calendar year and adjusted as necessary. For procedures without Medicare fee schedule values, reimbursement rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes.

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

1. Beginning April 1, 2015, the office will make adjustments to payments, as necessary, for services provided by eligible physicians and practitioners to Medicaid recipients in order to maintain adequate access to primary and specialty physician and practitioner services as required by 42 USC 1396a(a)(30) and 42 CFR 447.204 and to compensate eligible physicians and practitioners for their additional costs incurred in providing services to Medicaid patients. The office will make adjustments to payments ("Medicaid Payment Adjustments") as follows:

   a. Medicaid Payment Adjustments to eligible physicians and practitioners

      (1) Medicaid Payment Adjustments will be made by the office to eligible physicians and practitioners. To be an eligible physician or practitioner, the physician or practitioner must be:

         i. A faculty physician with an in-state medical school or one of the following types of practitioners:
            a. Certified Registered Nurse Anesthetist
            b. Nurse Practitioner
            c. Physician Assistant
            d. Certified Nurse Midwife
            e. Clinical Social Worker
            f. Clinical Psychologist
            g. Optometrist
         ii. Licensed by the State of Indiana;
         iii. An enrolled Indiana Medicaid provider; and
         iv. Employed by or affiliated with an eligible health institution.

      Eligible health institutions are: (a) Indiana University Health, Inc. and its affiliates and (b) Health and Hospital Corporation of Marion County and its affiliates.

      (2) Subject to 42 CFR 447.10 and (3) below, Medicaid Payment Adjustments will be made quarterly by the office, with an annual reconciliation, in an amount not to exceed the difference between Indiana Medicaid RBRVS fee schedule for eligible physicians and practitioners and in accordance with state plan attachment 4.19-B page 1, 1a, 1a.1, 1b and 1c for practitioners, and the Enhanced Payment, as defined in b.(4) below. Eligible physicians and practitioners who receive Medicaid payments as authorized by attachment 4.19-B, Page 1c.4b through d in the state plan shall also receive these Medicaid Payment Adjustments provided they meet the office's applicable performance standards as discussed in (3) below. Eligible practitioners will also be required to meet the office's performance standards.

      (3) The amounts of the Medicaid Payment Adjustments to eligible physicians and practitioners are subject to the office's performance standards. The office may adjust the eligible physician and practitioner Medicaid Payment Adjustments based upon the office's review and the eligible physicians' and practitioners' satisfaction of the office's performance standards in order to ensure access to care for Medicaid recipients. An annual review will be conducted to measure and evaluate whether eligible physicians and practitioners have met performance standards. The results of the annual review will be applied to the quarterly payments for the following calendar year. No less than annually, the office will report the results of the annual review to CMS.

b. Medicaid Payment Adjustment Calculation

(1) Calculate the Average Commercial Rate: For each procedure code for which the payment adjustments will be made ("eligible procedure codes"), compute the average commercial rate by CPT Code, and modifier if applicable, including patient share amounts, by the top five payers during the defined base period.

(2) Calculate the Medicaid Payment Ceiling: Multiply the Average Commercial Rate as determined in Paragraph (1) above, by the number of times each eligible procedure code, and modifier if applicable, was paid in the base period for Medicaid beneficiaries, to eligible physicians and practitioners, as reported in the claims data. Calculate the Total Medicaid Payment Ceiling by summing the product of each eligible procedure code.

(3) Calculate the Average Commercial Rate as a Percentage of Medicare, for all eligible physicians and practitioners

i. Calculate Total Medicare Payments: Multiply the Medicare non-facility rate per procedure code by the number of times each eligible procedure code, and modifier if applicable, was paid for Medicaid beneficiaries during the base period as reported in the claims data. Add the product for all eligible procedure codes, to equal the Total Medicare Payments.

ii. Divide the Medicaid Payment Ceiling by Total Medicare Payments. This ratio expresses the Average Commercial Rate as a Percentage of Medicare.

iii. The Average Commercial Rate as a Percentage of Medicare will be rebased/updated at least every three (3) years.

(4) Determination of Medicaid Payment Adjustment for each eligible physician or practitioner

i. Determine the Enhanced Payment:
For Eligible Physicians and Practitioners: Multiply the Average Commercial Rate as a Percentage of Medicare by the Medicare rate for each eligible procedure code, and modifier if applicable. Sum the product for all eligible procedure codes to equal the Enhanced Payment.

ii. Determine the Medicaid Payment Adjustment Prior to Application of Performance Standards: the Medicaid Payment Adjustment Prior to Application of Performance Standards, for eligible physicians and practitioners, shall equal the Enhanced Payment less all Medicaid payments for eligible procedure codes paid in the applicable period for Medicaid beneficiaries to eligible physicians and practitioners, as reported in the claims data.

iii. The Medicaid Payment Adjustment is calculated by multiplying the Medicaid Payment Adjustment Prior to Application of Performance Standards by the applicable factor for the eligible physician or practitioner's achievement of the performance standards as averaged by respective group practice.

iv. Performance standards as established by the office and effective beginning April 1, 2015, are described in the following table.

Performance Metric	Performance Target	Data and Monitoring
1. Percent of new patients seen in clinics in less than 7 days.	≥ 35%	• All physician group practices of eligible health institutions. • Monthly reporting of internal performance data with auditing / data checks as necessary.
2. Median lag time for clinic visits in all specialties.	≥ 55% of new patients seen within 3 weeks of request	• All physician group practices of eligible health institutions. • Monthly reporting of internal performance data with auditing / data checks as necessary.
3. Median time for patient to see a provider in the Emergency Department.	≤ 40 minutes	• All hospital emergency department facilities of the eligible institutions. • Data as reported to Medicare.gov for Hospital Compare per satisfaction survey schedule with auditing / data checks as necessary.
4. Patient Satisfaction: Patients who reported YES, they would definitely recommend the hospital or clinic.	≥ 70%	• All physician group practices, emergency departments, and outpatient clinics of eligible institutions. • Data as reported to Medicare.gov for Hospital Compare and Physician Compare per satisfaction survey schedule with auditing / data checks as necessary.

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

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

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

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

1) A percentage increase will be applied to the current Medicaid fee for the seventy-five (75) primary and preventative care services procedures, including evaluation and management procedures, certain delivery procedures, and preventative medicine procedures. Medicaid payments under this state plan amendment for FFY 2008 shall be based on historic claims paid between January 1, 2006 and March 31, 2007 ("Period 1"), and April 1, 2007 and August 31, 2007 ("Period 2"). The percentage payment increase for Period 1 claims shall be 23.68%, and the percentage for Period 2 claims shall be 37.52%. The resulting fee shall be limited to the Medicare fee in effect during 2007 for Indiana providers.
2) Historic claims for Periods 1 and 2 will be re-priced based on the service fee percentage increase identified above. Claims with third party payments or spend down amounts will be excluded.
3) The payment adjustment amount is equal to the difference between the original payment amount and the re-priced payment amount determined in step 2, and will be paid in a one-time lump sum payment to all five physician specialty practitioners, both governmental and private providers, providing these services. No payment adjustments will be made for services rendered after FFY 2008.

VIII. RBRVS Payment Reductions

The five percent (5%) reduction of all reimbursement to chiropractors and podiatrists for services provided on or after January 1, 2011 that has been calculated under methods described in Attachment 4.19-B is extended through December 31, 2013. The RBRVS rates are published at the State's website www.indianamedicaid.com.

The five percent (5%) reduction of all reimbursement to speech/hearing therapists, audiologists, optometrists, opticians, independent laboratory providers, and independent radiology providers, for services provided on or after July 1, 2011, that has been calculated under methods described in Attachment 4.19-B shall be extended through December 31, 2013. The RBRVS rates are published at the State's website www.dianamedicaid.com.

IX. Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

The state will develop a fee schedule using the most recent annual Medicare physician fee schedule rates for calendar years 2013 and 2014. The state will not make mid-year updates to the rates. Qualifying evaluation and management codes will be reimbursed at the lesser of billed charges or the Medicare physician fee schedule rates applicable in calendar years (CYs) 2013 and 2014, or if greater, the payment rates that would be applicable in those calendar years using the CY2009 Medicare physician fee schedule conversion factor.

Method of Payment

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency's fee schedule described in Attachment 4.19-B, page 1c.4b Physician Services of the State plan and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☒ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99339, 99340, 99358, 99359, 99360, 99363, 99364, 99366,99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99401, 99402, 99403, 99404, 99406, 99407, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99466, 99467, 99485, 99486, 99487, 99488, 99489, 99495, 99496

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99224 added 1/1/2011, 99225 added 1/1/2011, and 99226 added 1/1/2011

The state will not make an increased payment under this SPA for the following code that does not have Medicare RVUs and for which CMS will not develop a Medicare-like rate: 99499

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☒ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which

encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☒ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:
To impute the payment rate in effect at 7/1/09 for code 90460, the state will use the payment rate in effect on 7/1/09 for code 96372. This payment rate is $12.94.

For vaccination administration, the State will make payment for the following codes under this SPA: 90471, 90472, 90473, and 90474. For VFC vaccine administration, reimbursement will be the lesser of the state regional maximum administration fee set by the VFC program or the Medicare physician fee schedule rates in effect in CYs 2013 and 2014 (or, if greater, the payment rates that would be applicable in those calendar years using the CY 2009 Medicare physician fee schedule conversion factor). For non-VFC vaccine administration, reimbursement will be the lesser of billed charges or the Medicare physician fee schedule rates in effect in calendar years (CY) 2013 and 2014 (or, if greater, the payment rates that would be applicable in those calendar years using the CY 2009 Medicare physician fee schedule conversion factor).

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at the state's website www.indianamedicaid.com.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at the state's website www.indianamedicaid.com.

Reimbursement for Medically Necessary School Nursing Services

Reimbursement for medically necessary school nursing services provided by a nurse who is employed by or under contract with a school corporation that participates in Medicaid will be paid on a fee-for-service basis. Medically necessary school nursing services are similar in nature to HHA nursing services, Medically necessary school nursing services rates will be set using the same rate methodology currently in place for home health nursing services. Payment will be based on the lower of the provider's submitted charge or the established rate. The unit of service will be 15 minutes.

The state-developed fee schedule rate is available only to Indiana Medicaid enrolled local educational agencies (LEAs) which provide medically necessary school nursing services pursuant to a Medicaid enrolled student's educational program or plan as required by the Individuals with Disabilities Education Act (IDEA) or Section 504 of the federal Rehabilitation Act of 1973. 29 U.S.C. 794.. All rates are published on the State's website at: www.indianamedicaid.com.

Pharmacy Services

Reimbursement for covered federal legend drugs and for covered non-legend (OTC) drugs is at acquisition cost plus professional dispensing fee, as follows:

Federal legend Drugs

Payment is based on the lowest of:

(A) The National Average Drug Acquisition Cost (NADAC) as published by CMS pursuant to 42 U.S.C 1396r-8(f) plus the professional dispensing fee;

(B) The state maximum allowable cost (MAC) as determined by the office plus the professional dispensing fee;

(C) The federal upper limit (FUL) as determined by CMS pursuant to 42 C.F.R. 447.514 plus the professional dispensing fee;

(D) The wholesale acquisition cost (WAC) according to the office's drug database file contracted from a nationally recognized source such as Medi-Span or First DataBank, minus a percentage as determined by the office through analysis of the dispensing cost survey or other methodology approved by CMS, plus the professional dispensing fee. The purpose of the percentage is to ensure that the applicable WAC rate sufficiently reflects the actual acquisition cost of the provider. The WAC shall be considered only if there is no applicable NADAC, FUL, or state MAC rate;

(E) The provider's submitted charge, representing the provider's usual and customary charge for the service.

Non-legend (OTC) Drugs

Payment is based on the lowest of:

(A) State OTC MAC plus professional dispensing fee;

(B) The provider's submitted charge, representing the provider's usual and customary charge for the service.

The professional dispensing fee that is reimbursed to pharmacy providers is determined based on a cost of dispensing survey that is performed every two years. The survey identifies costs associated with the dispensing function of prescription services, regardless of product or setting. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacies.

Indiana Medicaid 340B Policy For Indiana Health Coverage Programs:

For drugs purchased through the 340B program, reimbursement will be at the provider's actual acquisition cost plus the professional dispensing fee.

For drugs purchased outside the 340B program, reimbursement will be as described under the heading "Federal Legend Drugs", above

Drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

Drugs Acquired at the Federal Supply Schedule (FSS):

If providers obtain drugs acquired at the federal supply fee schedule, Indiana Medicaid will reimburse at no more than the actual acquisition cost plus the professional dispensing fee.

Drugs Acquired at Nominal Price (Outside of 340B or FSS):

If providers obtain drugs acquired at nominal cost, Indiana Medicaid will reimburse at no more than the actual acquisition cost plus the professional dispensing fee. .

Encounter Rates (Drugs Dispensed by IHS/Tribal Facilities Under Encounter Rates):

All Indian Health Service, tribal and urban Indian pharmacies would be reimbursed an applicable encounter rate by Indiana Medicaid, regardless of their method of purchasing. Indiana does not have any Tribal Facilities billing for pharmacy services at this time.

Drugs Not Distributed by a Retail Community Pharmacy and Distributed Primarily Through the Mail (Such as Specialty Drugs):

Same policy as applies to drugs distributed by a retail community pharmacy. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacy services.

Drugs Not Distributed by a Retail Community Pharmacy (Such as a Long-Term Care Facility):

Same policy as applies to drugs distributed by a retail community pharmacy. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacy services.

Physician Administered Drugs

Physician-administered drugs are considered a physician service under Indiana Medicaid; as such, information regarding physician–administered drugs is contained in the physician services section of the state plan. Please refer to Attachment 4.19-B page 1f.

Blood Factor / Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers, Centers of Excellence:

Indiana Medicaid will reimburse for blood factor / clotting factor products using the same methodology as for federal legend drugs.

Investigational Drugs:

Investigational drugs, when deemed medically necessary on a case-by-case review basis, will be reimbursed at the actual acquisition cost plus the professional dispensing fee.

Physician-administered Drugs

Reimbursement for physician-administered drugs shall be one hundred five percent (105%) of the published wholesale acquisition cost (WAC) of the benchmark National Drug Code (NDC). For National Drug Codes without a published wholesale acquisition cost, the reimbursement for physician-administered drugs shall be one hundred six percent (106%) of the average sales price (ASP) payment amount as published by the Centers for Medicare and Medicaid Services (CMS). If neither the wholesale acquisition cost nor the average sales price are available, other pricing metrics may be used as determined by the office. The rates determined in accordance with this section shall be effective for services provided on or after May 1, 2010. These rates are published in provider bulletins, which are accessible through the agency's website. The State's website, www.indianamedicaid.com, allows providers access to all provider bulletins.

State of Indiana

1905(a)(29) Medication-Assisted Treatment (MAT)

Unbundled Prescribed Drugs and Biologicals

The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for Pharmacy Services located in Attachment 4.19-B, pages 1d and 1e, for drugs that are dispensed or administered.

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

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 1b-1c of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Application of the RBRVS reimbursement methodology for services provided by other licensed practitioners

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 1c of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Community Mental Health Centers

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 5a of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Upper Payment Limit Demonstration

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 2 of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Outpatient Hospital Services

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 2 of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Opioid Treatment Services

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 5c of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Intensive Outpatient Treatment (IOT)

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 5d of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.