TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #10-250(F)

DIGEST

Amends 405 IAC 1-11.5-2 to modify Medicaid reimbursement for physician-administered drugs, which shall not apply to parenteral nutrition and blood factor products. Effective 30 days after filing with the Publisher.

405 IAC 1-11.5-2

SECTION 1. 405 IAC 1-11.5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-11.5-2 Reimbursement methodology

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-13-2

Sec. 2. (a) The office shall establish fee schedules with maximum allowable payment amounts for services and procedures:
(1) covered under the Medicaid program; and
(2) provided by eligible physicians, LLPs, and other NPPs.

(b) The reimbursement for services of physicians and LLPs shall be determined as follows:
(1) Reimbursement for services of physicians and LLPs, except services of the physicians in subdivisions (3) through (10), shall be equal to the lower of the following:
(A) The submitted charges for the procedure.
(B) The established fee schedule allowance for the procedure. The statewide established fee schedule allowance for the procedure is based on the Medicare relative value unit for an Indiana urban locality multiplied by the conversion factor for the procedure as established by the office of Medicaid policy and planning (office).
(2) If no Medicare relative value unit, as defined in this section, exists for a procedure, reimbursement will be established as follows:
(A) Relative value units may be:
(i) obtained from other state Medicaid programs; or
(ii) developed specifically for the Indiana Medicaid program, subject to review by the Medicaid director.
(B) For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement will be made using the fee value in the national Medicare clinical laboratory fee schedule.
(3) The office may set reimbursement for specific procedure codes using a different methodology from that specified in subdivisions (1) and (2) in order to preserve access to the specific service.
(4) Reimbursement for services of anesthesiologists shall be based on a statewide fee schedule. The statewide fee schedule for anesthesiology services is based on the total base and time units for the procedure multiplied by the conversion factor as established by the office.
(5) Reimbursement for services of assistant surgeons shall be equal to twenty percent (20%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).
(6) Reimbursement for services of cosurgeons shall be paid at sixty-two and one-half percent (62.5%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).
(7) Reimbursement for services of physicians and LLPs shall be subject to the global surgery policy as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services. The global surgery policy will not apply to the following codes:
(A) 59410–Vaginal delivery, including postpartum care.
(B) 59515–Caesarean delivery, including postpartum care.
(8) Reimbursement for services of physicians and LLPs shall be subject to the policy for supplies and services incident to other procedures as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services.
(9) Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and in intra-arterial injections, if it is used for patients who meet the criteria established by the office.
(10) Reimbursement for services of physicians and LLPs shall be subject to the site of service payment

adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the statewide fee schedule for physician and LLP services as established under subdivision (1). These procedures are identified using the site of service indicator on the Medicare fee schedule database.

(c) Reimbursement for services of NPPs shall be in accordance with the following:
(1) Reimbursement for services of dentists in calendar year 1994 shall be based on a statewide fee schedule equal to a percentage of the fiscal year 1992 submitted charges. That percentage shall be not lower than the average percentage difference between physician and LLP submitted charges and the fee established for those services in accordance with subsection (b)(1). The office may set reimbursement for specific dental procedures using a different methodology from that specified in this subdivision in order to preserve access to the service. Beginning with the effective date of this revised rule, fees for covered dental services are priced at the levels in effect at the end of calendar year 1994, increased by a percentage determined by the office.
(2) Reimbursement for services of:
(A) social workers certified through the American Academy of Certified Social Workers (ACSW) or who have masters of social work (MSW) degrees;
(B) psychologists with basic certificates; and
(C) licensed psychologists;
providing outpatient mental health services in a physician-directed outpatient mental health facility in accordance with 405 IAC 5-20-8 shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must continue to be billed through a physician or a physician-directed outpatient mental health facility.
(3) Reimbursement for services provided by independently practicing respiratory therapists and advance practice nurses shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1).
(4) Reimbursement for services provided by certified physical therapists' assistants shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must be billed through the supervising licensed physical therapist or physician.
(5) Blood factor products used during an inpatient hospital stay shall be paid based on the state maximum allowable cost (state MAC) rate for the blood factor products. The state MAC rate for blood factor products is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual acquisition cost will be determined using pharmacy invoices and other information that the office determines is necessary. The office will review the state MAC rates for blood factor products on an ongoing basis and adjust the rates as necessary to:
(A) reflect the prevailing market conditions; and
(B) ensure reasonable access by inpatient hospital providers to blood factor products at or below the applicable state MAC rate.
Inpatient hospitals shall submit claims for reimbursement in accordance with the instructions set forth in the provider manual or update bulletins.
(6) Reimbursement for services of all other NPPs shall be equal to the statewide fee schedule for physician and LLP services as established under subsection (b)(1).

(d) The established rates for physician, LLP, and NPP reimbursement shall be reviewed annually by the office and adjusted as necessary.

(e) The relative value units used for the Indiana resource-based relative value scale fee schedule will be reviewed annually, taking into account the Medicare fee schedule proposed by the Health Care Financing Administration to take effect January 1 of the following calendar year and adjusted as necessary.

(f) 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 benchmark NDCs without a published WAC, the reimbursement for physician-administered drugs shall be the Medicare payment amount as published by the Centers for Medicare and Medicaid Services (CMS). If no WAC or Medicare payment amount is available, other pricing metrics may be used as determined by the office. This provision shall not apply to parenteral nutrition and blood factor products.

(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-2; filed Sep 6, 1994, 3:25 p.m.: 18 IR 88; errata filed Oct 18, 1994, 3:25 p.m.: 18 IR 532; filed Jun 21, 1995, 4:00 p.m.: 18 IR 2767; errata filed Sep 29, 1995, 1:30 p.m.: 19 IR 209; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1901; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Sep 12, 2008, 12:34 p.m.:

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Small Business Regulatory Coordinator: Yvonne Burke, Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning, Indiana Government Center South, 402 West Washington Street, Indianapolis, IN 46204, (317) 232-2017, yvonne.burke@fssa.in.gov

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