



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Medical Practitioner Reimbursement

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Medical Practitioner Reimbursement

*Note: The information in this module applies to medical practitioner reimbursement for Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system.*

*For services covered through a **managed care** program – such as Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise or Indiana PathWays for Aging (PathWays) – providers must refer to the member's managed care entity (MCE) for reimbursement information. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at in.gov/medicaid/providers.*

For updates to the information in this module, see [IHCP Bulletins](#) at in.gov/medicaid/providers.

Introduction

The Indiana Health Coverage Programs (IHCP) Professional Fee Schedule (accessible from the [IHCP Fee Schedules](#) page in.gov/medicaid/providers) contains a complete list of Current Procedural Terminology (CPT^{®1}) and other Healthcare Common Procedure Coding System (HCPCS) codes, as well as certain procedure code-modifier combinations, with pricing information for each covered service. Additional information – such as unit limits, age restrictions and prior authorization requirements – is also included, when applicable.

Physicians, limited license practitioners and other medical practitioners that bill the IHCP on a fee-for-service (FFS) basis should refer to the IHCP Professional Fee Schedule for reimbursement rates.

Certain circumstances, as described in the [Special Payment Situations](#) section, can result in an adjustment to the reimbursement amount indicated on the IHCP Professional Fee Schedule.

Note: For dates of service on or after Jan. 1, 2024, managed care entities (MCEs) are required to reimburse providers at or above the FFS rates for professional services covered under the member's benefit plan. The MCEs must use the IHCP Professional Fee Schedule as a minimum fee schedule.

Also effective Jan. 1, 2024, IHCP rates for physician services are aligned with 100% of the previous year's Medicare rates.

IHCP Professional Pricing Methods

Covered services on the IHCP Professional Fee Schedule are typically priced using a **resource-based relative value scale (RBRVS)** method. Where RBRVS is not applicable, services may be priced at a **maximum-fee amount** that is based on a different methodology. In either case, practitioners are reimbursed at the *lower of the following*: the submitted charge **or** the established statewide allowance for the procedure.

Additionally, some professional services are priced at a **percentage of the amount billed**, and some are **manually priced** based on documentation submitted, such as manufacturer's suggested retail price (MSRP) or cost invoice.

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The IHCP Professional Fee Schedule indicates the pricing method used for each covered service as follows:

- RBRVS – Resource-based relative value scale
- MAXFEE – Maximum fee (amount not based on RBRVS)
- BILLXX – Priced at XX% of the billed amount (for example, BILL90 indicates the service is reimbursed at 90% of the amount billed)
- SYSMAN – Suspends for review of documentation and manual assignment of pricing
- ANESTH – Anesthesia pricing

For services priced using the RBRVS or maximum-fee methods, a dollar amount is listed. For services that are manually priced or priced at a percentage of the amount billed, no dollar amount is listed. For services priced according to the anesthesiology calculation, the Fee Schedule amount is listed as \$0.00, and instead a base-unit value is listed. See Figure 1 for examples.

Figure 1 – Examples from the IHCP Professional Fee Schedule Showing Pricing Method and Amount

Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Category	Service Category Desc	Rate Type	Pricing Method	Pricing Effective Date	Pricing End Date	PA Req'd	Attach Req'd
93797					MEDSV	Medical Services	Def	RBRVS	2/1/2015			
Min-Max Units					Fee Schedule Amt: \$11.69		Base Units:		Age Min-Max:			
Procedure Desc:		CARDIAC REHAB					CMS Add Date:		1/1/1990	CMS Term Date:		
59425					MEDSV	Medical Services	Def	MAXFEE	2/1/2015			
Min-Max Units		0 - 6			Fee Schedule Amt: \$72.61		Base Units:		0	Age Min-Max: 8 - 60 years		
Procedure Desc:		ANTEPARTUM CARE ONLY					CMS Add Date:		1/1/1994	CMS Term Date:		
V2785					VISIO	Vision	Def	SYSMAN				Y
Min-Max Units					Fee Schedule Amt:		Base Units:		Age Min-Max:			
Procedure Desc:		CORNEAL TISSUE PROCESSING					CMS Add Date:		1/1/1990	CMS Term Date:		
50549					MEDSV	Medical Services	Def	BILL35				Y
Min-Max Units		0 - 1			Fee Schedule Amt:		Base Units:		Age Min-Max:			
Procedure Desc:		LAPAROSCOPE PROC RENAL					CMS Add Date:		1/1/2000	CMS Term Date:		
00100					ANEST	Anesthesia	Def	ANESTH	1/1/1900			
Min-Max Units					Fee Schedule Amt: \$0.00		Base Units:		5	Age Min-Max:		
Procedure Desc:		ANESTH SALIVARY GLAND					CMS Add Date:		1/1/1989	CMS Term Date:		

Resource-Based Relative Value Scale Components

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

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

The RBRVS reimbursement methodology includes Medicare-based relative value units (RVUs) and a conversion factor. Individual RVUs for each procedure have been developed to represent the resource use associated with individual procedures. The IHCP Professional Fee Schedule amount for these procedures is based on statewide RVUs that have been adjusted to reflect work, practice and malpractice costs in Indiana. Effective for dates of service on or after Jan. 1, 2024, the IHCP uses the geographic practice cost index (GPCI) from the previous year's Medicare Physician Fee Schedule to adjust the RVU components for Indiana. For example, for 2024, the IHCP uses the 2023 Medicare GPCI for Indiana, as follows:

- Physician work – 1.000
- Practice expense – 0.911
- Malpractice expense – 0.475

To compute the payment rate for a procedure that is reimbursed under the RBRVS methodology, the IHCP first calculates the total base RVUs according to this formula:

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

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

$$\text{Payment Rate} = \text{Total Base RVUs} \times \text{RBRVS Conversion Factor}$$

Effective for dates of service on or after Jan. 1, 2024, the IHCP uses the RBRVS conversion factor from the previous year's Medicare Physician Fee Schedule to calculate the current year's Indiana Medicaid payment rates. For example, for 2024, the IHCP uses the 2023 Medicare RBRVS conversion factor of \$33.8872.

When RVUs Are Unavailable

IHCP-covered procedures that have RVUs on the Medicare Physician Fee Schedule are reimbursed using the RBRVS methodology described in the previous section.

However, some procedures on the Medicare Physician Fee Schedule do not have RVUs to be used with the RBRVS methodology. RVUs are not available for procedures on the Medicare Physician Fee Schedule if the procedure is categorized as one of the following:

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

IHCP-covered procedures that fall into one of these categories are reimbursed either as **maximum fee** (the lower of the submitted charge or the maximum-allowed fee determined using a method other than RBRVS), or through **manual pricing**, depending on the specific procedure.

For details about special reimbursement methodology used for certain types of services, see the applicable module: [Laboratory Services](#), [Radiology Services](#), [Anesthesia Services](#) or [Durable and Home Medical Equipment and Supplies](#).

Special Payment Situations

Certain situations result in special payment provisions within the RBRVS and maximum-fee payment methodologies. As described in the following sections, the use of certain pricing modifiers and other factors (such as the specialty under which a practitioner is enrolled) may result in an adjustment to the payment amount, instead of the full rate indicated on the fee schedule.

For services that are reimbursed according to RBRVS and maximum fee methodologies, the reduction is applied to the maximum allowed amount (the amount indicated on the IHCP Professional Fee Schedule), *not* the billed amount. Therefore, the amount paid for these services is either the amount billed or the adjusted maximum allowed amount, whichever is lower. These reimbursement reductions do not apply for manually priced codes or codes that are priced at a percentage of the amount billed.

For services rendered through a federally qualified health center (FQHC) or rural health clinic (RHC), reimbursement is based on provider-specific encounter methodology. See the [Federally Qualified Health Centers and Rural Health Clinics](#) module for details.

Note: For information about Hospital Assessment Fee adjustments for professional services, see the [Hospital Assessment Fee](#) module.

Advanced Practice Registered Nurses

The IHCP requires all advanced practice registered nurses (APRNs) to enroll as IHCP providers (type 09), with one of the following specialties:

- 090 – *Pediatric Nurse Practitioner*
- 091 – *Obstetric Nurse Practitioner*
- 092 – *Family Nurse Practitioner*
- 093 – *Clinical Nurse Specialist*
- 094 – *Certified Registered Nurse Anesthetist (CRNA)*
- 095 – *Certified Nurse Midwife*

For dates of service on or after Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), the IHCP reimburses **services rendered by CRNAs** (specialty 094) as follows:

- **Up to 50%** of the IHCP Professional Fee Schedule amount if the service is provided under the medical direction of a physician. Medically directed CRNA services must be billed with modifier QX.
- **Up to 100%** of the IHCP Professional Fee Schedule amount if service is not provided under the medical direction of a physician. CRNA services that are not medically directed must be billed with modifier QZ.

The appropriate modifier, QX or QZ, must be included with all CRNA-rendered services, regardless of whether the CRNA's National Provider Identifier (NPI) is entered as the rendering provider on the claim, or the service is billed under a supervising physician's NPI. See the [Anesthesia Services](#) module for additional CRNA billing and reimbursement information.

For dates of service on or after Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), the IHCP reimburses **services rendered by all other APRNs** (specialties 090–093 and 095) at **up to 85%** of the IHCP Professional Fee Schedule amount. This adjusted rate applies regardless of whether the APRN is enrolled as a billing provider, as a rendering provider within an APRN group enrollment, or as a rendering provider employed by a physician or working in a physician-directed group or clinic – and regardless of whether the APRN is working within the behavioral health arena. If the APRN-rendered service is billed under the NPI of a supervising practitioner, the SA modifier must be included; for behavioral health service claims, both the SA and HE modifiers are required. If the service is billed under the APRN's own NPI, no modifiers are required.

The following exceptions apply:

- Medicaid Rehabilitation Option (MRO) services are reimbursed at **100%** of the IHCP Professional Fee Schedule amount for all allowable rendering practitioners, including APRNs. Neither modifier SA nor HE should be used when billing MRO services rendered by an APRN but using the NPI of a supervising practitioner. The services should be billed using only the approved MRO modifiers, as described in the [Medicaid Rehabilitation Option Services](#) module.
- Effective for dates of service on or after Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), when an APRN acts as an assistant at surgery, the service is reimbursed at **up to 13.6%** of the IHCP Professional Fee Schedule amount (which is 85% of the adjusted rate that would be paid to a *physician* acting as assistant at surgery). When billing for APRN assistant-at-surgery services, the **AS** modifier must be included. Only certain services allow for reimbursement of an assistant during surgery. See the [Surgical Services](#) module for details.

Providers cannot bill separately for APRN services in outpatient hospital settings when the APRN is employed by the hospital. These services are included in the hospital outpatient reimbursement rate.

*Note: For dates of service prior to Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), the IHCP reimbursed all **CRNA** services at up to 60% of the IHCP Professional Fee Schedule amount, regardless of whether or not they were medically directed, and it reimbursed all **other APRN** services as follows:*

- **Up to 75%** of the IHCP Professional Fee Schedule amount for APRNs (other than CRNAs) enrolled as a billing provider or as a rendering provider within an APRN group enrollment
- **Up to 100%** of the IHCP Professional Fee Schedule amount for APRNs (other than CRNAs) employed by physicians or working in a physician-directed group or clinic (and not working in the behavioral health arena)
- **Up to 75%** of the IHCP Professional Fee Schedule amount for APRNs working in the behavioral health arena (billed using modifier HE), including those working under a physician or physician-directed group.

*When an APRN acted as assistant at surgery, the service was reimbursed at **up to 20%** of the IHCP Professional Fee Schedule amount.*

Physician Assistants

The IHCP requires all physician assistants to enroll as IHCP providers (type 10, specialty 100) as either a billing or a rendering provider. Physician services must be billed using the physician assistant's own NPI on the claim. Effective for dates of service on or after Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), the IHCP reimburses for physician assistant services at **up to 85%** of the IHCP Professional Fee Schedule amount.

Also effective for dates of service on or after Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), when a physician assistant acts as assistant at surgery, the service will be reimbursed at **up to 13.6%** of the IHCP Professional Fee Schedule amount (which is 85% of the adjusted rate that would be paid to a *physician* acting as assistant at surgery). When billing for services where a physician assistant acted as assistant at surgery, the **AS** modifier must be included. Only certain services allow for reimbursement of an assistant during surgery. See the [Surgical Services](#) module for details.

Providers cannot bill separately for physician assistant services in outpatient hospital settings when the physician assistant is employed by the hospital. These services are included in the hospital outpatient reimbursement rate.

*Note: For dates of service prior to Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), the IHCP reimbursed physician assistant services at up to 75% of the IHCP Professional Fee Schedule amount. When a physician assistant acted as the assistant at surgery, the service was reimbursed at **up to 20%** of the IHCP Professional Fee Schedule amount.*

Behavioral Health Practitioners

For dates of service on or after Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), the IHCP reimburses behavioral health services at **up to 100%** of the IHCP Professional Fee Schedule rate when rendered by the following practitioners:

- Physician (type 31) with an applicable specialty, such as a psychiatrist (specialty 339)
- Psychologist endorsed as a health service provider in psychology (HSPP) (type 11, specialty 114)
- Licensed psychologist (type 11, specialty 616)
- Licensed independent practice school psychologist (type 11, specialty 617)

All *other* behavioral health practitioners, including the following specialties, are reimbursed at a reduced rate of up to **75%** of the IHCP Professional Fee Schedule amount:

- Licensed clinical social worker (LCSW) (type 11, specialty 618)
- Licensed marriage and family therapist (LMFT) (type 11, specialty 619)
- Licensed mental health counselor (LMHC) (type 11, specialty 620)
- Licensed clinical addiction counselor (LCAC) (type 11, specialty 621)

Behavioral health services rendered by qualified practitioners who are **not** enrolled in the IHCP must be submitted using the NPI of an IHCP-enrolled practitioner as the rendering provider, and the procedure code must be billed with modifier **HE** – *Services provided by any behavioral health practitioner (excluding physicians, HSPPs and physician assistants)*. This same guidance applies in cases where the rendering practitioner is enrolled, but the provider *chooses* to bill the service using a supervising practitioner's NPI.

*Note: Effective Jan. 1, 2025, the IHCP requires the use of modifier **HE** to signify behavioral health services provided by any eligible practitioner, when billed under another practitioner's NPI. Physicians, HSPPs and physician assistants are always required to bill under their own NPI.*

As an exception to the guidance in this section, MRO services are reimbursed at up to 100% of the IHCP Professional Fee Schedule amount for all rendering practitioners meeting the qualifications for the service. Modifier HE should not be used for MRO services, regardless of whether the NPI entered for the rendering provider is that of a supervising practitioner rather than the behavioral health practitioner who delivered the service. See the [Medicaid Rehabilitation Option Services](#) module for more information.

Providers cannot bill separately for services rendered by behavioral health practitioners in outpatient hospital settings when the practitioner is employed by the hospital. These services are included in the hospital outpatient reimbursement rate.

For more information about billing and reimbursement for behavioral health services, see the [Behavioral Health Services](#) module.

*Note: For dates of service **prior to** Jan. 1, 2024 (for managed care) and April 1, 2024 (for FFS), the IHCP reimbursed licensed psychologists and licensed independent practice school psychologists at up to 75% of the IHCP Professional Fee Schedule amount.*

Nonenrolled Therapy Practitioners

The IHCP reimburses enrolled physical therapists, occupational therapists and speech/hearing therapists (type 17, specialties 170–173) at the full IHCP Professional Fee Schedule rate for applicable services.

Therapy services rendered by practitioners who are **not** eligible for IHCP enrollment but who meet certain qualifications are reimbursed at an adjusted rate. These services must be billed under the NPI of an IHCP-enrolled supervising practitioner, as follows:

- Physical therapist assistant (PTA) – Procedures performed by certified PTAs must be billed with modifier **HM** and are reimbursed at **up to 75%** of the rate paid to a physical therapist. Reimbursement for these practitioners is limited to designated services only and must be provided under the direct supervision of a licensed physical therapist or physician.
- Speech-language pathologist aides – Procedures performed by registered speech-language pathologist aides must be billed with the modifier **HM** and are reimbursed at **up to 75%** of the rate paid to a speech-language pathologist. Services must be supervised by a licensed speech-language pathologist (enrolled under IHCP specialty 173) and are subject to *880 IAC 1-2.1*.

See the [Therapy Services](#) module for more information.

Community Health Workers

The IHCP provides reimbursement for services rendered by community health workers (CHWs).

CHWs are required to be employed by an IHCP-enrolled billing provider and to deliver services under the supervision of one of the following IHCP-enrolled provider types:

- Physician
- Health service provider in psychology (HSPP)
- Advanced practice registered nurse (APRN)
- Physician assistant
- Podiatrist
- Chiropractor

The billing provider must maintain documentation of CHW certification for each individual providing CHW services, as described in the [Provider Enrollment](#) module.

Covered CHW Services and Service Limits

The IHCP covers the following CHW services:

- Diagnosis-related patient education for members regarding self-managing physical or mental health, in conjunction with a healthcare team – This service allows a CHW to extend education efforts associated with any physical or mental health concern that a member may encounter.
- Facilitation of cultural brokering between a member and the member's healthcare team – This service allows a CHW to act as a facilitator between a Medicaid member and a provider when cultural factors (such as language or socioeconomic status) become a barrier to properly understanding treatment options or treatment plans.
- Health promotion education to a member on behalf of the healthcare team to prevent chronic illness – This service allows a CHW to discuss and promote healthy behaviors with a member to increase awareness and avoid the development of chronic illnesses.
- Direct preventive services or services aimed at slowing the progression of chronic diseases

The IHCP does **not** cover the following CHW services:

- Insurance enrollment and “navigator” assistance
- Case management and care coordination
- Arranging for transportation or providing transportation for a member to and from services
- Direct patient care outside the level of training and certification an individual has attained

Covered CHW services must be provided face-to-face with the member, individually or in a group, in an outpatient, home, clinic or other community setting.

The IHCP limits reimbursement of covered CHW services to:

- Four units (or two hours) per day per member
- Twenty-four units (or 12 hours) per month per member

The billing provider must maintain documentation of medical necessity for any services provided by a CHW.

CHW Billing and Reimbursement

Covered CHW services must be billed on the professional claim using the following procedure codes:

- 98960 – *Self-management education & training, face-to-face, 1 patient*
- 98961 – *Self-management education & training, face-to-face, 2–4 patients*
- 98962 – *Self-management education & training, face-to-face, 5–8 patients*

These procedure codes should be billed in 30-minute units. Separate claim lines (details) should be billed for each date that services were provided. Claims must include an appropriate diagnosis. The supervising practitioner’s NPI must be listed as the rendering provider on the claim, and the name of the CHW must be included in the claim notes.

CHW services are reimbursed at the rate shown on the IHCP Professional Fee Schedule. The IHCP prices procedure codes 98960–98962 at 50% of RBRVS amount.

Note: Hospital Assessment Fee (HAF) adjustments are not available for CHW services.

Surgery-Related Modifiers

In addition to the payment differential for certain types of practitioners, IHCP reimbursement rates can also be affected by pricing modifiers and policies related to surgical services billed on the professional claim. See the [Surgical Services](#) module for billing requirements and rate adjustments related to the following surgical situations:

- Assistant surgeon – Modifiers 80, 81 and 82
- Co-surgeon/two surgeons – Modifier 62
- Team surgeon – Modifier 66
- Intraoperative services only – Modifier 54
- Postoperative services only – Modifier 55
- Return to surgery – Modifier 78
- Bilateral surgery – Modifier 50
- Multiple procedures – Modifier 51

Provider Preventable Conditions

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

The IHCP will deny payments for inpatient, outpatient and professional claims (including Medicare and Medicare Advantage Plan crossover claims) when provider preventable conditions (PPCs) are performed on a patient. Providers may not bill the member for PPCs or related services upon denial of reimbursement by the IHCP.

For a list of PPC diagnosis codes, see *Surgical Services Codes* on the [Code Sets](#) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers). When such services are submitted on professional claims, the following PPC modifiers must be included indicating errors:

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

Site-of-Service Payment Adjustment

Procedures that are performed in a non-office setting that are normally provided in a physician's office or other office setting are subject to a site-of-service payment adjustment that is based on Medicare facility practice expense (PE) RVUs when the procedure is, instead, provided in one of the following Medicaid or Medicare places of service, as indicated by the following place of service (POS) codes:

- Medicaid POS:
 - 19 – *Off campus – outpatient hospital*
 - 22 – *On campus – outpatient hospital*
 - 23 – *Emergency room – hospital*
 - 62 – *Comprehensive outpatient rehabilitation facility*
- Medicare POS:
 - 02 – *Telehealth provided other than in patient's home*
 - 19 – *Off campus – outpatient hospital*
 - 21 – *Inpatient hospital*
 - 22 – *On campus – outpatient hospital*
 - 23 – *Emergency room – hospital*
 - 24 – *Ambulatory surgical center (ASC)*
 - 26 – *Military treatment facility*
 - 31 – *Skilled nursing facility (SNF)*
 - 34 – *Hospice*
 - 41 – *Ambulance – land*
 - 42 – *Ambulance – air or water*
 - 51 – *Inpatient psychiatric facility*
 - 52 – *Psychiatric facility – partial hospitalization*
 - 53 – *Community mental health center*
 - 56 – *Psychiatric residential treatment center*
 - 61 – *Comprehensive inpatient rehabilitation facility*

Whether a managed care entity (MCE) applies the site-of-service adjustment depends on the reimbursement policies of the MCE.

B-Bundled Codes Not Separately Reimbursable

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