INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Medical Practitioner Reimbursement

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 28, 2016	Scheduled update	FSSA and HPE
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4.0	Policies and procedures as of July 1, 2022 Published: Dec. 19, 2022	Scheduled update: • Edited text as needed for clarity • Revised terminology to distinguish "priced at a percentage of the amount billed" from "manually priced" • Added information about MRO reimbursement rates to the *Advanced Practice Registered Nurses* and *Behavioral Health Practitioners* sections	FSSA and Gainwell

Table of Contents

Medical Practitioner Reimbursement

*Note: The information in this module applies to medical practitioner reimbursement related to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. Within the managed care delivery system, individual managed care entities (MCEs) establish their own reimbursement methodologies. For information about medical practitioner reimbursement for services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise member services – providers must contact the member's MCE or refer to the MCE provider manual. 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 banner pages and bulletins at in.gov/medicaid/providers.

Introduction

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

The 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.

Certain circumstances, as described in the *Special Payment Situations* section, can result in an adjustment to the reimbursement amount indicated on the Professional Fee Schedule.

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 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.

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)
- BILL*XX* – 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

[1] *CPT copyright 2022 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

For services priced using the RBVRS 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 components of the RBRVS reimbursement methodology include the Medicare-based relative value units (RVUs) and a conversion factor. Individual RVUs for each procedure have been developed to represent the resource use associated with individual procedures. The IHCP 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. Indiana specifically developed a statewide geographic practice cost index (GPCI) as follows:

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

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

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

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

Payment Rate = Total Base RVUs × RBRVS Conversion Factor

The Indiana RBRVS conversion factor is $26.8671.

Services on the IHCP Professional Fee Schedule are priced using this RBVRS methodology if the following criteria are met:

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

When RVUs Are Inappropriate or Unavailable

Most IHCP-covered procedures that have RVUs on the Medicare Physician Fee Schedule are reimbursed using the RBVRS methodology described in the previous section. However, for some procedures with RVUs, such as maternity and delivery services, the RBVRS methodology is not appropriate. The IHCP reimburses these procedures at the lower of the submitted charge or the maximum fee allowed for that procedure, where the maximum fee is *not* determined using RVUs.

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 RBVRS), 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* or *Anesthesia Services*.

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, not the billed amount. Therefore, the amount paid for these services is 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), using 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 CRNAs (specialty 094), the IHCP reimburses all services at up to **60%** of the IHCP allowed amount. See the *Anesthesia Services* module for additional CRNA billing and reimbursement information.

For all *other* APRNs (specialties 090–093 and 095), the IHCP reimbursement rate depends on whether the APRN that rendered the service is: (A) enrolled as a billing provider or as a rendering provider within an APRN group enrollment, **or** (B) employed by a physician or working in a physician-directed group or clinic:

A. The IHCP reimburses for service rendered by APRNs (other than CRNAs) who are **enrolled as a billing provider or as a rendering provider within an APRN group enrollment** at up to **75%** of the IHCP Professional Fee Schedule amount. These APRN services must be billed as follows:
   - Enter the APRN's own National Provider Identifier (NPI) in the rendering provider field (in the bottom portion of field 24J on the *CMS-1500* claim form or equivalent field of the electronic claim). Enter the NPI of the billing entity in the billing provider field (in field 33a on the *CMS-1500* claim form or equivalent field of the electronic claim).

B. The IHCP reimburses for service rendered by APRNs (other than CRNAs) who are **employed by physicians or are working in a physician-directed group or clinic** at up to **100%** of the IHCP Professional Fee Schedule amount. These APRN services can be billed in *either* of the following ways:
   - Enter the APRN's own NPI in the rendering provider field. Enter the NPI of the billing entity in the billing provider field.
   - Enter the supervising physician's NPI in the rendering provider field, and include the **SA** modifier with the services billed. The NPI of the billing entity must be entered in the billing provider field.

In all cases, medical records must clearly identify the provider that actually rendered the services.

> *Note: APRNs serving as primary medical providers (PMPs) **must** bill using their own NPI as the rendering provider for services they rendered to members on their PMP panel.*

The following exceptions apply to the previously indicated reimbursement rates and billing guidance for APRN services:

- Within the behavioral health arena, APRNs (including those working under a physician or physician-directed group) are reimbursed at up to **75%** of the IHCP Professional Fee Schedule amount. If the APRN is billing under the NPI of a supervising physician, modifier **HE** should be included along with modifier **SA**, to indicate that the APRN is working within the behavioral health arena, and a 25% rate reduction will be applied as described in the *Behavioral Health Services* module.
- 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.
- When an APRN acts as an assistant at surgery, the service is reimbursed at up to **20%** of the IHCP Professional Fee Schedule amount, regardless of how the APRN is enrolled and regardless of whether the service is billed using the APRN's NPI or that of a supervising physician. 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.

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. The IHCP reimbursement rate for physician assistant services is up to **75%** of the IHCP Professional Fee Schedule amount.

When a physician assistant acts as assistant at surgery, the **AS** modifier must be included. An 80% reduction will be applied, rather than the usual 25% reduction for this specialty, meaning the service will be reimbursed at up to 20% of the IHCP Professional Fee Schedule amount. 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.

Behavioral Health Practitioners

The IHCP reimburses behavioral health services rendered by a physician (such as a psychiatrist) or a psychologist endorsed as a health service providers in psychology (HSPP) at the full IHCP rate. 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 Psychologist (type 11, specialty 616)
- Licensed Independent Practice School Psychologist (type 11, specialty 617)
- 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 practitioners who are not enrolled in the IHCP must be submitted using the supervising practitioner's NPI as the rendering provider and modifier **HE** – *Services provided by any behavioral health practitioner (excluding physicians, HSPPs and physician assistants)*.

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* 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.

Nonenrolled Therapy Practitioners

The IHCP reimburses enrolled physical therapists, occupational therapists and speech/hearing therapists at the full rate for applicable services.

Therapy services rendered by practitioners that are not eligible for IHCP enrollment but that meet certain qualifications as described in the *Therapy Services* module 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 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 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 – *Speech/Hearing Therapist*) 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 services 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. Covered CHW services are limited to four units (or two hours) per day, per member and to 24 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
- Cosurgeon – 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 (PPC) 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. 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 normally performed in a physician's office are subject to a site-of-service payment adjustment that is 80% of the practice expense component of the statewide RBVRS rate when the procedure is provided in one of the following outpatient places of service:

- 19 – *Off campus-outpatient hospital*
- 22 – *On campus-outpatient hospital*
- 23 – *Emergency room*
- 62 – *Comprehensive outpatient rehabilitation facility*

Whether a managed care entity (MCE) applies the site-of-site 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 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.

Reimbursement for the Promoting Interoperability Program

The Indiana Medicaid Promoting Interoperability Program provides incentives to eligible professionals and hospitals for adopting, implementing, upgrading or demonstrating meaningful use of certified electronic health records technology. To participate, providers must have registered for the program with both the CMS and the IHCP no later than program year 2016.

> *Note: The Indiana Medicaid Promoting Interoperability Program is no longer accepting new registrations. Incentive payments for currently participating providers continued through 2021. No incentive payments are being made after December 31, 2021.*

Reimbursement for this program is made through Medical Assistance Provider Incentive Repository (MAPIR) payment system, accessible via the Portal. See the *Indiana Medicaid Promoting Interoperability Program* page at in.gov/medicaid/providers for details about the Promoting Interoperability Program and MAPIR payment system.