

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION
42 CFR 447.201

Medical and Remedial Care and Services- Item 5

State: Louisiana
Date Received: 9 June, 2014
Date Approved: 29 July, 2014
Date Effective: 20 May, 2014
Transmittal Number: 14-20

I. Method of Payment

Effective February 1, 1987, the Medicaid Program began implementation of a statewide flat fee-for-service reimbursement methodology for services provided by professional services providers such as, but not limited to physicians, osteopaths, optometrists, dentists, and nurse-midwives. In order to determine flat-fee amounts, we compared billed charges, maximum allowable prices on file, and average amounts paid for the full service aspect of all payable CPT procedure codes for calendar year 1984. This review was conducted by Medicaid Program staff and consultant physicians. Prices for full service were adjusted only when the maximum allowable payment for a given procedure was found to be out of line with the difficulty of the procedure. Other types of service prices were calculated using the same percentage formula as that used by Medicare (20% of full service for assistant surgeon, 40% of full service for professional component only). For services added as newly payable, Medicare state-wide prevailing fees were obtained and reduced by 30%. For items of care, services and procedure not covered by Medicare Part B, and no reasonable charges were set by the Medicare contractor, prices were based on review of statewide billed charges for that service in comparison with set charges for similar services or, if no similar services, based upon consultant physicians' review and recommendations of reasonable charges. National Medicare Laboratory Fee Schedules were adopted for those laboratory services covered by the Fee Schedule.

Changes in the established flat rate which are found to be necessary for any item of care, service or procedure shall be reviewed as follows:

The Medicaid Program shall review and make changes based on statewide billed charges for that service in comparison with set charges for similar services, and consultant physicians' review and recommendations of reasonable charges. For items of care, services, and procedures that do not have charges set by the Medicare contractor, the Medicaid Program shall make changes based upon review of statewide billed charges for that service in comparison with set charges for similar services or, if no similar services, based upon consultant physician' review and recommendations of reasonable charges.

The reimbursement fee for items of care, services and procedures then becomes the maximum allowable payable under the Medicaid Program. Each item of care, service, and procedure has assigned to it a Health Care Procedure Code (HCPC). For each HCPC a maximum reimbursement (flat-fee) is assigned and automated payment is made based on the flat-fee amount assigned to each HCPC, not to exceed billed charges.

Effective May 20, 2014, the reimbursement for newly payable services not covered by Medicare, when there is no established rate set by Medicare, shall be based on review of statewide billed charges for that service in comparison with set charges of similar services.

1. If there is no similar procedure or service, the reimbursement shall be based upon a consultant physicians' review and recommendations.
2. For procedures which do not have established Medicare fees, the Department of Health and Hospitals, or its designee, shall make determinations based upon a review of statewide billed charges for that service in comparison with set charges for similar services.
3. Reimbursement shall be the lesser of the billed charges or the Medicaid fee on file.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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Reimbursement for certain bilateral procedures listed in the Professional Services Provider Manual shall be at 150% of the fee on the published Medicaid fee schedule when performed bilaterally.

Surgical services modified with modifier 63 (procedure performed on infants less than 4kg) shall be reimbursed at 125 percent of the Medicaid fee on file.

Effective for dates of service on or after January 1, 2008, the reimbursement for selected physician services shall be 90 percent of the 2008 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount, unless otherwise stipulated.

The reimbursement shall remain the same for those services that are currently being reimbursed at a rate that is between 90 percent and 120 percent of the 2008 Louisiana Medicare Region 99 allowable.

For those services that are currently reimbursed at a rate above 120 percent of the 2008 Louisiana Medicare Region 99 allowable, effective for dates of service on or after January 1, 2008, the reimbursement for these services shall be reduced to 120 percent of the 2008 Louisiana Medicare Region 99 allowable.

Effective for dates of service on or after August 4, 2009, the reimbursement for all physician services rendered to recipients 16 years of age or older shall be reduced to 80 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

Effective for dates of services on or after August 4, 2009, those services that are currently reimbursed at a rate below 80 percent of the Louisiana Medicare Region 99 allowable, will be reimbursed at a rate of 80 percent of the Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

The following physician services are excluded from the rate adjustment:

- Preventive medicine evaluation and management;
- Immunizations;
- Family planning services;
- Select orthopedic reparative services; and
- Prenatal evaluation & management and delivery services.

State: Louisiana
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Effective for the dates of service on or after January 22, 2010, the reimbursement rates for family planning services shall be reduced to 75 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is less.

Effective for dates of service on or after July 1, 2012, reimbursement shall be as follows for the designated physician services:

1. Reimbursement for professional services procedure (consult) codes 99241-99245 and 99251-99255 shall be discontinued;
2. Cesarean delivery fees (procedure codes 59514-59515) shall be reduced to equal corresponding vaginal delivery fees (procedure codes 59409-59410); and
3. Reimbursement for all other professional services procedure codes, shall be reduced by 3.4 percent of rates on file as of June 30, 2012.

TN# 13-36 Approval Date 12/5/13 Effective Date 8/20/13
Supersedes
TN# 12-26

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

Attachment 4.19-B
Item 5, Page 2a

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Effective for dates of service on or after July 1, 2012, the reimbursement rates for family planning services rendered by a physician shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

Effective for dates of service on or after February 1, 2013, the reimbursement for certain physician services shall be reduced by 1 percent of the rate in effect on January 31, 2013. Specified primary care services rendered by a physician with a specialty designation of family medicine, internal medicine, or pediatrics shall be excluded from the February 1, 2013 rate reduction. Rates for such services are exempt from the rate reduction, paralleling the January 1, 2013 implementation of Affordable Care Act requirements for Medicaid to reimburse at the Medicare rate for such services rendered in calendar years 2013 and 2014.

Effective for dates of services on or after February 20, 2013, the 3.7 percent reimbursement rate reduction for family planning services rendered by a physician shall be adjusted to 3.4 percent of the rates in effect on June 30, 2012

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Supersedes
TN# 13-06

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Anesthesia Services

A. The most appropriate procedure codes and modifiers shall be used when billing for surgical anesthesia procedures and/or other services performed under the professional licensure of the physician (anesthesiologist or other specialty).

B. Formula Based Reimbursement.

Reimbursement is based on formulas related to 100 percent of the 2003 Medicare Region 99 payable.

Effective for dates of service on or after July 1, 2012, the reimbursement for formula-based anesthesia services shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

Effective for dates of service on or after July 20, 2012, the 3.7 percent reimbursement rate reduction for formula-based anesthesia services shall be adjusted to 3.4 percent of the rates in effect on June 30, 2012.

C. Flat Fee Reimbursement.

Reimbursement for maternity related anesthesia services is a flat fee except for general anesthesia related to a vaginal delivery which is reimbursed according to a formula.

Other anesthesia services that are performed under the professional licensure of the physician (anesthesiologist or other specialty) are reimbursed a flat fee based on the appropriate procedure code.

Effective for dates of service on or after July 1, 2012, the flat fee reimbursement rates paid for anesthesia services shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

Effective for dates of service on or after July 20, 2012, the 3.7 percent reimbursement rate reduction for flat fee reimbursement of anesthesia services shall be adjusted to 3.4 percent of the rates in effect on June 30, 2012.

D. Maternity Related Anesthesia Services

The delivering physician will be reimbursed when he initiates the epidural procedure with inclusion of the appropriate procedure code and modifier.

The anesthesiologist or CRNA who is called in to continue administering the anesthesia after the epidural was inserted will be reimbursed for the continued administration of the anesthesia.

Anesthesiologists and/or CRNAs may not bill for both continued administration and general anesthesia.

TN# 12-34 Approval Date 8/22/13
Supersedes
TN# 12-25 Effective Date: 7/20/12

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

E. Surgeons shall not be reimbursed for the personal medical direction of a CRNA. The anesthesia service will be considered non-medically directed and should be billed as such by the CRNA.

F. Effective for dates of service on or after August 4, 2009, the reimbursement rates paid for anesthesia services that are performed under the professional licensure of a physician (anesthesiologist or other specialty) shall be reduced by 3.5 percent of the rates in effect on August 3, 2009.

Note: Reimbursement for anesthesia services performed by certified registered nurse anesthetists (CRNAs) is listed in Item 6.d.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(a) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

A. Payment for Physician Services for recipients eligible for Title XVIII Part B.

Title XVIII-B provides for payment per calendar year for physician services for a Medicare eligible in the amount of 80% of the physician's reasonable usual and customary charge after the annual deductible is met. The Medicaid Program pays for Medicare covered services in accordance with the limitations set forth in Section 3.2 and Attachment of the Plan.

B. Recipients not Eligible for Title XVIII Part B.

Payment for physician services for recipients not covered under Title XVIII Part B will be made subject to flat fee limitations or billed charges whichever is lower and subject to service limitations.

SUPERSEDES: TN- 07-33

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| STATE <u>Louisiana</u> | A |
| DATE REC'D <u>12-27-07</u> | |
| DATE APPOVD <u>3-18-08</u> | |
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

C. Diabetes Education Services Reimbursement

1. Effective for dates of service on or after February 21, 2011, the Medicaid Program shall provide reimbursement for diabetes self-management training services rendered by qualified health care professionals.
2. Reimbursement for DSMT services shall be a flat fee based on the appropriate Healthcare Common Procedure Coding (HCPC) code.

D. Fluoride Varnish Application Services

1. Effective for dates of service on or after December 1, 2011, the Medicaid Program shall provide reimbursement for fluoride varnish application services to recipients under the age of 6 years rendered by qualified health care professionals in a physician office setting.
2. Reimbursement for fluoride varnish application services shall be a flat fee based on the appropriate HCPCS code.

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STATE OF LOUISIANA

MENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Citation Medical and Remedial
42 CFR 440.50 Care and Services
 Item 5. (cont.)

II. Standards for Payment

A. Physician Services

Only the services of doctors of medicine or osteopathy who are licensed as physicians by the State Board of Medical Examiners are reimbursed.

B. Teaching Physicians

Reimbursement is available to the teaching physician who meets the following minimum conditions as an "attending physician".

- (1) Review the patient's history, record of examinations and the tests in the institution, and make frequent reviews of the patient's progress; and
- (2) Personally examine the patient; and
- (3) Confirm or revise the diagnosis and determine the course of treatment to be followed; and
- (4) Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents or others that the care meets a proper quality level.

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STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION

42 CFR 450.30;

Medical and Remedial
Care and Services
Item 5. (cont.)

(5) Be present and ready to perform any service performed by an attending physician in a non-teaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed for a physician to be an "attending physician" his attendance as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from a medical standpoint; and

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(6) Be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

To be the "attending physician" for a portion of a patient's hospital stay. A teaching physician may be held to be the attending physician for a portion of a patient's hospital stay:

(1) If the portion is a distinct segment of the patient's course of treatment (e.g., the pre-operative or post-operative period) and of sufficient duration to impose on the physician a substantial responsibility for the continuity of the patient's care; and

(2) If the physician, as a minimum, performs all of the activities described above with respect to that portion of the stay and if the physician is recognized as the patient's physician fully responsible for that part of the stay. If a teaching physician is not found to be the attending physician with respect to a portion of a patient's stay, he may not be reimbursed for any service provided to the patient for that portion of the stay unless it is an identifiable service that he personally rendered to the patient.

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In these situations reimbursement for the combined segments of patient care may not exceed the rate set for that physician had he/she been the attending physician for the entire service.

C. Physician Services for Abortion

Payment will be made to the attending physician for abortions when the physician has found, and certified in writing to the Medicaid Agency, that on the basis of his professional judgment, the mother suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself placing the mother in danger of death unless an abortion is performed.

Payment will be made to the attending physician for abortions terminating pregnancies resulting from rape or incest in accordance with provisions of State law (La R.S. 40:1299.34.5 and La. R.S. 40:1299.35.7 as amended and enacted by Act 1 of the Fourth Extraordinary Session of the 1994 Legislature.)

D. RESERVED

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

E. Optometry Services

1. Effective October 1, 2012, eye care services rendered by a participating optometrist, within their scope of optometric practice, shall be classified and reimbursed under the Medicaid State Plan as a mandatory physician service to the same extent, and according to the same standards as physicians who perform the same eye care services.
2. Recipients in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program are excluded from optometry service limits.
3. The Medicaid Program shall not provide reimbursement for eyeglasses provided to Medicaid recipients 21 years of age or older.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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Physician-Administered 17 Hydroxyprogesterone (17P)

Effective for dates of service on or after June 20, 2015, the reimbursement for the administration of the drug, 17 Hydroxyprogesterone (17P), shall increase to \$69 per dose.

The reimbursement rate is listed in the Louisiana Medicaid Professional Services Fee Schedule at: http://www.lamedicaid.com/provweb1/fee_schedules/FEESCHED.pdf

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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III. Supplemental Payments for Physicians and Other Professional Service Practitioners

State-Owned or Operated Entities

1. Physicians and other eligible professional service practitioners must meet the following requirements in order to qualify to receive supplemental payments. The physician or professional service practitioner must be:

- a. licensed by the State of Louisiana;
- b. enrolled as a Louisiana Medicaid provider;
- c. employed by a state-owned or operated entity, such as state-operated hospital or other state entity including a state academic health system, which has been designated by the Bureau as an essential provider and which has furnished satisfactory data to DHH regarding the commercial insurance payments made to its employed physicians and other professional service practitioners. Essential providers include:

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- LSU School of Medicine – New Orleans
- LSU School of Medicine – Shreveport
- LSU/ State Operated Hospitals
 - Dr. Walter Olin Moss Regional Medical Center
 - E.A. Conway Medical Center
 - Earl K. Long Medical Center
 - Huey P. Long Medical Center
 - Lallie Kemp Regional Medical Center
 - Leonard J. Chabert Medical Center
 - LSU Health Sciences Center
 - Medical Center of Louisiana
 - University Medical Center
 - Washington-St. Tammany Regional Medical Center
 - Villa Feliciana Geriatric Hospital

2. Payment Methodology:

- a. The supplemental payment to each qualifying physician or other eligible professional services practitioner will equal the difference between the Medicaid payments otherwise made to these qualifying providers for professional services and the average amount that would have been paid at the equivalent community rate. The community rate is defined as the average amount that would have been paid by commercial insurers for the same services.

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TN# 05-05 05-05

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

The supplemental payment to each qualifying physician or practitioner shall be calculated by applying a community rate conversion factor to actual charges for claims paid during a quarter for Medicaid services provided by the qualifying state-employed physician or practitioner. This community rate conversion factor shall be established annually for qualifying providers by determining the amount that private commercial insurance companies paid for commercial claims submitted by the state-employed providers and dividing that amount by the respective charges for these payers. The commercial payments and respective charges shall be furnished for the state fiscal year preceding the reimbursement calendar year. If the required data is not provided, the default conversion factor shall equal "1".

The actual charges for Medicaid services paid in the quarter shall then be multiplied by the conversion factor to determine the maximum allowable Medicaid reimbursement. For eligible non-physician practitioners, the maximum allowable Medicaid reimbursement shall be limited to 80 percent of this amount. Then the actual base Medicaid payments to the qualifying state-employed physician or practitioner shall be subtracted from the maximum Medicaid reimbursement amount to determine the supplemental payment amount.

- b. The supplemental payment for services provided will be issued through quarterly supplemental payments to providers based on specific MMIS paid claims data. Supplemental payments will be made subsequent to the delivery of services.
- c. Supplemental payments will be paid for services provided at or through a state-owned or operated entity that has been designated as an essential provider. Services provided at a non-state-owned facility will not be considered to be provided through an essential provider if the other facility bills for the service.

SUPERSEDES: NONE - NEW PAGE

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| DATE EFF <u>4-1-05</u> | |
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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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Non-State Owned or Operated Governmental Entities

1. Qualifying Criteria

Physicians and other eligible professional service practitioners as specified in 2. below who are employed by, or under contract to provide services at, a non-state owned or operated governmental entity may qualify for supplemental payments for services rendered to Medicaid recipients. To qualify for the supplemental payment, the physician or professional service practitioner must be:

- a. licensed by the State of Louisiana;
- b. enrolled as a Louisiana Medicaid provider; and
- c. identified by the non-state owned or operated governmental entity as a physician that is employed by, or under contract to provide services at the non-state owned or operated governmental entity.

2. Qualifying Provider Types

For purposes of qualifying for supplemental payments under this section, services provided by the following professional practitioners will be included:

- a. Physicians;
- b. Physician Assistants;
- c. Certified Registered Nurse Practitioners; and,
- d. Certified Registered Nurse Anesthetists.

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3. Payment Methodology

The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The community rate level is defined as the rates paid by commercial payers for the same service. Under this methodology the terms physician and physician services include services provided by all qualifying provider types as set forth in 2. above.

The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

- a. For services provided by physicians at a non-state governmental hospital, the state will collect from the hospital its current commercial physician fees by CPT code for the hospital's top three commercial payers by volume.
- b. The state will calculate the average commercial fee for each CPT code for each physician practice plan or physician that provides services at the non-state governmental hospital.

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- c. The state will extract from its paid claims history file for the preceding fiscal year all paid claims for those physicians who will qualify for a supplemental payment. The state will align the average commercial fee for each CPT code as determined in b. above to each Medicaid claim for that physician or physician practice plan and calculate the average commercial payments for the claims.
- d. The state will also align the same paid Medicaid claims with the Medicare fees for each CPT code for the physician or physician practice plan and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees.
- e. The state will then calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio will be re-determined every three years.
- f. For each quarter the state will extract paid Medicaid claims for each qualifying physician or physician practice plan for that quarter.
- g. The state will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available national non-facility fees.
- h. The total amount that Medicare would have paid for those claims is then multiplied by the Medicare to commercial conversion factor and the amount Medicaid actually paid for those claims is subtracted to establish the supplemental payment amount for the physician or physician practice plan for that quarter.

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4. Effective Date of Payment

The supplemental payment will be made effective for services provided on or after July 1, 2010. This payment is based on the Medicare equivalent of the average commercial rate and is set using the Medicare physician fee schedule for hospital based services rendered by the qualifying providers. After the initial calculation for fiscal year 2010-2011, Louisiana will rebase the Medicare equivalent of the average commercial rate using adjudicated claims data for dates of services from the most recently completed fiscal year. This calculation will be made every three years. A link to the Medicare fee schedule used to determine the payment factor will be posted on the Louisiana Medicaid website at www.lamedicaid.com.

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Practitioners Affiliated with Tulane School of Medicine.

1. Qualifying Criteria

A. Effective for dates of service on or after July 1, 2012, physicians and other eligible professional service practitioners who are employed by, or under contract to provide services to Tulane University School of Medicine located in the city of New Orleans may qualify for supplemental payments for services rendered to Medicaid recipients. To qualify for the supplemental payment, the physician or professional service practitioner must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. identified by Tulane University School of Medicine as a physician or other professional service practitioner that is employed by, or under contract to provide services for that entity.

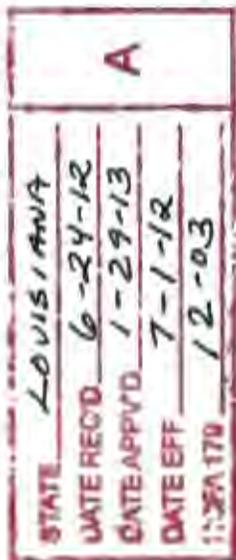
B. The following professional services practitioners shall qualify to receive supplemental payments:

1. physicians;
2. physician assistants;
3. certified registered nurse practitioners; and
4. certified registered nurse anesthetists.

2. Reimbursement Methodology

The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The community rate level is defined as the rates paid by commercial payers for the same service. Under this methodology the terms physician and physician services include services provided by all qualifying provider types as set forth in (B) above.

The base average commercial factor calculated for SFY 13 is 118.20% of Medicare.



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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

- a. For services provided by physicians at a non-state governmental hospital, the state will collect from the hospital its current commercial physician fees by CPT code for the hospital's top three commercial payers by volume.
- b. The state will calculate the average commercial fee for each CPT code for each physician practice plan or physician that provides services at the non-state governmental hospital.
- c. The state will extract from its paid claims history file for the preceding fiscal year all paid claims for those physicians who will qualify for a supplemental payment. The state will align the average commercial fee for each CPT code as determined in b. above to each Medicaid claim for that physician or physician practice plan and calculate the average commercial payments for the claims.
- d. The state will also align the same paid Medicaid claims with the Medicare fees for each CPT code for the physician or physician practice plan and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees.
- e. The state will then calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio will be re-determined every three years.
- f. For each quarter the state will extract paid Medicaid claims for each qualifying physician or physician practice plan for that quarter.
- g. The state will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available national non-facility fees.
- h. The total amount that Medicare would have paid for those claims is then multiplied by the Medicare to commercial conversion factor and the amount Medicaid actually paid for those claims is subtracted to establish the supplemental payment amount for the physician or physician practice plan for that quarter.

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**Physician Services: 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.

- For dates of service on or after February 20, 2013, the rate paid will be based on the site of service and the mean rate over all counties (parishes).
- For dates of service from January 1, 2013 through February 19, 2013 the rate paid will be based on the office setting and mean rate over all counties (parishes)
- The rates reflect all Medicare geographic/locality adjustments.
- The rates are statewide and reflect the mean value over all counties (parishes) 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: Rates were calculated based on the January 2, 2013 release of the Medicare geographic practice cost index (GPCI) factors and 2009 RVUs issued by CMS.

Mean over all parishes/counties per code = (4/64 x GPICs for Region 01) + (60/64 x GPICs for Region 99)

Region 01 New Orleans, LA

Region 99 Rest of Louisiana

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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 July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: monthly quarterly

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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): 99217; 99261-99275; 99288-99290; 99293-99303; 99311-99313; 99318-99323; 99331-99333; 99339-99340; 99351-99359; 99361-99373; 99375-99376; 99378; 99401-99420; 99431-99456; 99485-99496.

The State did make payment as of July 1, 2009 for the following codes but has since made them non-payable (see effective dates below). The State will not make payment for these codes under this SPA.

- 90465-90468: Non-payable as of January 1, 2011
- 99241-99255: Non-payable as of July 1, 2012

(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).

- 99224-99226: Payable as of January 1, 2011

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 for billing codes 90471 and 90473

Rate using the CY 2009 conversion factor for billing codes 90472 and 90474

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.

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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:

90460 and 90461 are non-covered. Providers must bill 90471 - 90474. The rates in effect on July 1, 2009 will be used as the basis for the July 1, 2009 rates.

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

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. All rates are published at www.lamedicaid.com.

Vaccine Administration Services: This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014. All rates are published at www.lamedicaid.com.

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