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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #03-164(F)

DIGEST

Amends 405 IAC 1-8-2 to clarify that ambulatory surgical center services are covered within the scope of 405 IAC 1-8. Amends 405 IAC 1-8-3 to eliminate outpatient reimbursement for outpatient hospital and ambulatory surgical center services occurring within three calendar days of an inpatient admission for the same or related diagnosis. The amendments also change the basis of rates that were established using data from 1992 to indicate that rates will be based on the fee schedule amounts during state fiscal year 2003 and include conforming changes and other changes to reflect current operant policies. Amends 405 IAC 1-10.5-2 and 405 IAC 1-10.5-3 to define marginal cost factor; clarify the definition of a Medicaid day; modify inpatient reimbursement to pay the lower of provider charges or diagnosis related grouping (DRG) and level of care (LOC) inpatient rates; include the costs of outpatient hospital and ambulatory surgical center services that lead to an inpatient admission when determining relative weights; indicate that readmissions for the same or related diagnoses within three calendar days after discharge will be treated as the same admission for payment purposes; eliminate DRG payments for Medicaid recipients subsequent to their return from a transferee hospital; and changes the reimbursement methodology for inpatient hospital stays less than one-day to the outpatient methodology. Makes conforming changes and other changes to reflect current operant policies. Effective 30 days after filing with the secretary of state.

405 IAC 1-8-2 **405 IAC 1-10.5-2**
405 IAC 1-8-3 **405 IAC 1-10.5-3**

SECTION 1. 405 IAC 1-8-2 IS AMENDED TO READ AS FOLLOWS:

Rule 8. Hospital and Ambulatory Surgical Center Reimbursement for Outpatient Services

405 IAC 1-8-2 Policy; scope
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 2. (a) Reimbursement for outpatient hospital services as defined by 42 CFR 440.20(a) **and to ambulatory surgical centers** is available to providers enrolled by the office of Medicaid policy and planning (office) as Medicaid providers who are in good standing. Continued participation in the Medicaid program and payment for outpatient hospital services **and ambulatory surgical centers** are contingent upon maintenance of state licensure and conformance with the office's provider agreement.

(b) The methodology for the reimbursement described in subsection (a) shall be based on set fee schedule allowances for each procedure or occurrence as established by the office of Medicaid policy and planning. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-2; filed Dec 2, 1993, 2:00 p.m.: 17 IR 735; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2247)*

SECTION 2. 405 IAC 1-8-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-8-3 Reimbursement methodology
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 3. (a) The reimbursement methodology for all covered outpatient **hospital and ambulatory surgical center** services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure as

provided in this section. ~~All~~ Services ~~will~~ **shall** be billed ~~on the uniform billing form, using both revenue codes and HCPCS codes. The appropriate HCPCS code, if one exists for the billed procedure, will be required in addition to the revenue code.~~ **in accordance with provider manuals and update bulletins.**

(b) Surgical procedures shall be classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology and shall be paid a rate established for each ASC payment group. Outpatient surgeries ~~which~~ **that** are not classified into the nine (9) groups designated by Medicare will be classified by the office into one (1) of those nine (9) groups or additional payment groups. Reimbursement will be based on ~~a blended rate equal to fifty percent (50%) of~~ the ~~Medicare ASC rate and fifty percent (50%) of the fiscal year 1992~~ Indiana Medicaid statewide ~~median~~ allowed amount for that service ~~Hospitals will bill for surgeries using a HCPCS code.~~ **in effect during state fiscal year 2003.**

(c) ~~Emergency~~ **Payments for emergent** care ~~(as identified by the outpatient hospital~~ **that do not include surgery and that are provided in an emergency** department, ~~payment~~ **treatment room, observation room, or clinic** will be based on ~~a~~ **the** statewide fee schedule ~~per HCPCS code. The fee schedule amount will be equal to the Indiana Medicaid statewide median amount paid per service during fiscal year 1992. Claims for services designated as emergency by a hospital will be subject to audit on a postpayment basis to validate that a bona fide emergency existed.~~ **amount in effect during state fiscal year 2003.**

(d) ~~Nonemergency~~ **Payments for nonemergent** care ~~determined by the office and as identified by nonemergency diagnosis codes,~~ that ~~is~~ **do not include surgery and that are** provided in an emergency **department, treatment** room, ~~shall~~ **observation room, or clinic will** be ~~paid~~ based ~~upon a nonemergency setting (for example, a clinic)~~ **on the statewide** fee schedule ~~established by the office. This fee schedule~~ amount ~~will be equal to the Indiana Medicaid statewide median amount paid per service~~ **in effect** during **state** fiscal year ~~1992. Hospitals will bill using HCPCS codes.~~ **2003.**

(e) Reimbursement for laboratory procedures ~~and~~ **is based on the Medicare fee schedule amounts. Reimbursement for** the technical component of radiology procedures ~~shall be~~ **is** based on ~~ninety-five percent (95%) of the Medicare allowance that was in effect prior to federal adoption of the Resource Based Relative Value Scale (RBRVS) for Medicare services. These services will be billed by HCPCS.~~ **the statewide fee schedule amount in effect during state fiscal year 2003.**

(f) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., shall be equal to the Indiana Medicaid statewide ~~median amount paid per service~~ **fee schedule amounts in effect** during **state** fiscal year ~~1992. All other services will be billed using a combination of HCPCS and revenue codes.~~ **2003.**

(g) Payments will not be made for outpatient hospital and ambulatory surgical center services occurring within three (3) calendar days preceding an inpatient admission for the same or related diagnosis. The office may exclude certain services or categories of service from this requirement. Such exclusions will be described in provider manuals and update bulletins.

~~(g)~~ **(h)** The established rates for hospital outpatient **and ambulatory surgical center** reimbursement shall be reviewed annually by the office and adjusted, as necessary, in accordance with this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-3; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2247)*

SECTION 3. 405 IAC 1-10.5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-2 Definitions
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1; IC 12-24-1-3; IC 12-25; IC 16-21

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Allowable costs" means Medicare allowable costs as defined by 42 U.S.C. 1395(f).

(c) "All patient DRG grouper" refers to a classification system used to assign inpatient stays to DRGs.

(d) "Base amount" means the rate per Medicaid stay, which is multiplied by the relative weight to determine the DRG rate.

(e) "Base period" means the fiscal years used for calculation of the prospective payment rates including base amounts and relative weights.

(f) "Capital costs" are costs associated with the capital costs of the facility. ~~Capital costs include,~~ **The term includes,** but ~~are~~ **is** not limited to, the following:
(1) Depreciation.
(2) Interest.
(3) Property taxes.
(4) Property insurance.

(g) "Children's hospital" means a freestanding general acute care hospital licensed under IC 16-21 that:
(1) is designated by the Medicare program as a children's hospital; or
(2) furnishes services to inpatients who are predominantly individuals under ~~the age of~~ eighteen (18) **years of age,** as determined using the same criteria used by the Medicare program to determine whether a hospital's services are furnished to inpatients who are predominantly individuals under ~~the age of~~ eighteen (18) **years of age.**
"Freestanding" does not mean a wing or specialized unit within a general acute care hospital.

(h) "Cost outlier case" means a Medicaid stay that exceeds a predetermined threshold, defined as the greater of twice the DRG rate or a fixed dollar amount established by the office. ~~The initial fixed dollar amount for the threshold is twenty-five thousand dollars ($25,000).~~ This amount may be changed at the time the relative weights are adjusted.

(i) "Diagnosis-related group" or "DRG" means a classification of an inpatient stay according to the principal diagnosis, procedures performed, and other factors that reflect clinically cohesive groupings of inpatient hospital stays utilizing similar hospital resources. Classification is made through the use of the all patient (AP) DRG grouper.

(j) "Discharge" means the release of a patient from an acute care facility. Patients may be discharged to their home, another health care facility, or due to death. Transfers from one (1) unit in a hospital to another unit in the same hospital shall not be considered a discharge unless one (1) of the units is paid according to the level-of-care approach.

(k) "DRG daily rate" means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the average length of stay for all stays classified into the DRG.

(l) "DRG rate" means the product of the relative weight multiplied by the base amount. It is the amount paid to reimburse hospitals for routine and ancillary costs of providing care for an inpatient stay.

~~(m) "Hospital Market Basket Index" means the DRI-Type Hospital Market Basket Index, published quarterly by DRI/McGraw-Hill in "Health Care Costs".~~

~~(n)~~ **(m)** "Inpatient" means a patient who was admitted to a medical facility on the recommendation of a physician and who received room, board, and professional services in the facility.

~~(o)~~ **(n)** "Inpatient hospital facility" means:
(1) a general acute hospital licensed under IC 16-21;
(2) a mental health institution licensed under IC 12-25;
(3) a state mental health institution under IC 12-24-1-3; or
(4) a rehabilitation inpatient facility.

~~(p)~~ **(o)** "Less than one-day stay" means a medical stay of less than twenty-four (24) hours. ~~that is paid according to a DRG rate.~~

~~(q)~~ **(p)** "Level-of-care case" means a medical stay, as defined by the office, that ~~is not part of the DRG reimbursement system. Level-of-care cases include~~ **includes** psychiatric cases, rehabilitation cases, **long term care hospital admissions,** and certain burn cases.

~~(r)~~ **(q)** "Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure ~~that is not~~

~~paid through the DRG payment system.~~ **subject to subsection (p).**

~~(s)~~ **(r)** "Long term care hospital" means a freestanding general acute care hospital licensed under IC 16-21 that:
(1) is designated by the Medicare program as a long term hospital; or
(2) has an average inpatient length of stay greater than twenty-five (25) days as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days.
"Freestanding" does not mean a wing or specialized unit within a general acute care hospital.

(s) "Marginal cost factor" means a percentage applied to the difference between the cost per stay and the outlier threshold for purposes of the cost outlier computation.

(t) "Medicaid day" means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day. **The term does not include any portion of an outpatient service under 405 IAC 1-8-3 that precedes an admission as an inpatient subject to subsection (m).**

(u) "Medicaid stay" means an episode of care provided in an inpatient setting that includes at least one (1) night in the hospital and is covered by the Indiana Medicaid program.

(v) "Medical education costs" means the direct costs associated with the salaries and benefits of medical interns and residents and paramedical education programs.

(w) "Office" means the office of Medicaid policy and planning of the family and social services administration.

(x) "Outlier payment amount" means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

(y) "Per diem" means an all-inclusive rate per day that includes routine and ancillary costs and capital costs.

(z) "Principal diagnosis" means the diagnosis, as described by ICD-9-CM code, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

(aa) "Readmission" means that a patient is admitted into the hospital ~~within fifteen (15) days~~ following a previous hospital admission and discharge for a related condition as defined by the office.

(bb) "Rebasing" means the process of adjusting the base amount using more recent claims data, cost report data, and other information relevant to hospital reimbursement.

(cc) "Relative weight" means a numeric value ~~which~~ **that** reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

(dd) "Routine and ancillary costs" means costs that are incurred in providing services exclusive of medical education and capital costs.

(ee) "Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient from one (1) unit to another unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

(ff) "Transferee hospital" means that hospital that accepts a transfer from another hospital.

(gg) "Transferring hospital" means the hospital that initially admits and then discharges the patient to another hospital. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-2; filed Oct 5, 1994, 11:10 a.m.: 18 IR 244; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1082; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1514; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 55; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2248)*

SECTION 4. 405 IAC 1-10.5-3, AS AMENDED AT 27 IR 863, SECTION 1, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-3 Prospective reimbursement methodology
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 3. (a) The purpose of this section is to establish a prospective, cost-based reimbursement methodology for services provided by inpatient hospital facilities that are covered by the state of Indiana Medicaid program. The methodology for reimbursement described in this section shall be a prospective system wherein a payment rate for each hospital stay will be established according to a DRG reimbursement methodology or a level-of-care reimbursement methodology. Prospective payment shall constitute full reimbursement **unless otherwise indicated herein or as indicated in provider manuals and update bulletins.** There shall be no year-end cost settlement payments.

(b) Rebasing of the DRG and level-of-care methodologies will apply information from the most recent available cost report that has been filed and audited by the office or its contractor.

(c) Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the **lower of billed charges or the** sum of the DRG rate, the capital rate, the medical education rate, and, if applicable, the outlier payment amount.

(d) Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the **lower of billed charges or the** sum of the per diem rate for each Medicaid day, the capital rate, the medical education rate, and, if applicable, the outlier payment amount (burn cases only).

(e) Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all patient DRG grouper.

(f) The DRG rate is equal to the product of the relative weight and the base amount.

(g) ~~Initial relative weights were calculated using Indiana Medicaid claims data for inpatient stays with dates of admission within state fiscal years 1990, 1991, and 1992 and cost report data from facilities' fiscal year 1990 cost reports.~~ Relative weights will be reviewed by the office and adjusted no more often than annually by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. Interim adjustments to the relative weights will not be made except in response to legislative mandates affecting Medicaid participating hospitals. Each legislative mandate will be evaluated individually to determine whether an adjustment to the relative weights will be made. DRG average length of stay values and outlier thresholds will be revised when relative weights are adjusted. **The office shall include the costs of outpatient hospital and ambulatory surgical center services that lead to an inpatient admission when determining relative weights. Such costs occurring within three (3) calendar days of an inpatient admission will not be eligible for outpatient reimbursement under 405 IAC 1-8-3. For reporting purposes, the day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.**

(h) ~~Initial base amounts were calculated using cost report data from facilities' fiscal year 1990 as-settled cost reports. Cost report data were inflated to the midpoint of the state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index available at the end of the 1993 calendar year.~~ Base amounts will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services.

(i) The office may establish a separate base amount for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate base amount. Children's hospitals with a case mix adjusted cost per discharge greater than one (1) standard deviation above the mean cost per discharge for DRG services will be eligible to receive the separate base amount established under this subsection. The separate base amount is equal to one hundred ~~and~~ twenty percent (120%) of the statewide base amount for DRG services.

(j) ~~Initial level-of-care payment rates were calculated using Indiana Medicaid claims data for inpatient stays with dates of admission within state fiscal years 1990, 1991, and 1992 and cost report data from facilities' fiscal year 1990 cost reports. Cost report data was inflated to the midpoint of the state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index.~~

Level-of-care rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. The office shall not set separate level-of-care rates for different categories of facilities except as specifically noted in this section.

(k) Level-of-care cases are categorized as DRG numbers 424–428, 429 (excluding diagnosis code 317.XX–319.XX), 430–432, 456–459, 462, and 472, as defined and grouped using the all patient DRG grouper, version 14.1. These DRG numbers represent burn, psychiatric, and rehabilitative care.

(l) In addition to the burn level-of-care rate, the office may establish an enhanced burn level-of-care rate for hospitals with specialized burn facilities, equipment, and resources for treating severe burn cases. In order to be eligible for the enhanced burn rate, facilities must offer a burn intensive care unit.

(m) The office may establish separate level-of-care rates for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate level-of-care rate. Children's hospitals with a cost per day greater than one (1) standard deviation above the mean cost per day for level-of-care services will be eligible to receive the separate base amount. Determinations will be made for each level-of-care category. The separate base amount is equal to one hundred twenty percent (120%) of the statewide level-of-care rate.

(n) The office may establish separate level-of-care rates, policies, billing instructions, and frequency for long term care hospitals to the extent necessary to reflect differences in treatment patterns for patients in such facilities. Hospitals must meet the definition of long term hospital set forth in this rule to be eligible for the separate level-of-care rate.

(o) Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. ~~The initial flat, statewide per diem capital rate was calculated using cost report data from facilities' fiscal year 1990 cost reports, inflated to the midpoint of state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index and adjusted to reflect a minimum occupancy level for non-nursery beds of eighty percent (80%).~~ Capital per diem rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the capital costs associated with efficiently providing hospital services. **Capital payment rates shall be adjusted to reflect a minimum occupancy level for nonnursery beds of eighty percent (80%).**

(p) The capital payment amount for Medicaid stays reimbursed under the DRG methodology shall be equal to the product of the per diem capital rate and the average length of stay for all cases within the particular DRG. Medicaid stays reimbursed under the level-of-care methodology will be paid the per diem capital rate for each covered day of care. The office shall not set separate capital per diem rates for different categories of facilities except as specifically noted in this rule.

(q) Medical education rates shall be prospective, hospital-specific per diem amounts. The medical education payment amount for stays reimbursed under the DRG methodology shall be equal to the product of the medical education per diem rate and the average length of stay for the DRG. Payment amounts for medical education for stays reimbursed under the level-of-care methodology shall be equal to the medical education per diem rate for each covered day of care.

(r) Facility-specific, per diem medical education rates shall be based on medical education costs per day multiplied by the number of residents reported by the facility. ~~Initial costs per resident per day were determined according to each facility's fiscal year 1990 cost report.~~ In subsequent years, but no more often than every second year, the office will use the most recent cost report data that has been filed and audited by the office or its contractor to determine a medical education cost per day that more accurately reflects the cost of efficiently providing hospital services. For hospitals with approved graduate medical education programs, the number of residents will be determined according to the most recent available cost report that has been filed and audited by the office or its contractor. Indirect medical education costs shall not be reimbursed.

(s) Medical education payments will only be available to hospitals that continue to operate medical education programs. Hospitals must notify the office within thirty (30) days following discontinuance of their medical education program.

(t) For hospitals with new medical education programs, the corresponding medical education per diem will not be effective prior

to notification to the office that the program has been implemented. The medical education per diem shall be based on the most recent reliable claims data and cost report data.

(u) Cost outlier cases are determined according to a threshold established by the office. For purposes of establishing outlier payment amounts, prospective determination of costs per inpatient stay shall be calculated by multiplying a cost-to-charge ratio by submitted and approved charges. Outlier payment amounts shall be equal to ~~a percentage of~~ **the marginal cost factor multiplied by** the difference between the prospective cost per stay and the outlier threshold amount. Cost outlier payments are not available for cases reimbursed using the level-of-care methodology except for burn cases that exceed the established threshold.

(v) Readmissions **for a related condition as defined by the office within three (3) calendar days after discharge will be treated as the same admission for payment purposes. Readmissions that occur after three (3) calendar days** will be treated as separate stays for payment purposes but will be subject to medical review. ~~If it is determined that a discharge is premature, payment made as a result of the discharge or readmission may be subject to recoupment.~~

(w) Special payment policies shall apply to **certain** transfer cases. The transferee, or receiving, hospital is paid according to the DRG methodology or level-of-care methodology. The transferring hospital is paid the sum of the following:

(1) A DRG daily rate for each Medicaid day of the recipient's stay, not to exceed the appropriate full DRG payment, or the level-of-care per diem payment rate for each Medicaid day of care provided.

(2) The capital per diem rate.

(3) The medical education per diem rate. Certain DRGs are established to specifically include only transfer cases; for these DRGs, reimbursement shall be equal to the DRG rate.

(x) Hospitals will not receive separate DRG payments for Medicaid patients subsequent to their return from a transferee hospital. Additional costs incurred as a result of a patient's return from a transferee hospital are eligible for cost outlier reimbursement subject to subsection (u). The office may establish a separate outlier threshold or marginal cost factor for such cases.

~~(x)~~ **(y)** Special payment policies shall apply to less than ~~one-day~~ **twenty-four (24) hour** stays. ~~that are paid according to a DRG rate.~~ For less than ~~one-day~~ **twenty-four (24) hour** stays, hospitals will be paid ~~a DRG daily rate, the capital per diem rate for one (1) day of stay, and the medical education per diem rate for one (1) day of stay, if applicable.~~ **under the outpatient reimbursement methodology as described in 405 IAC 1-8-3.** *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-3; filed Oct 5, 1994, 11:10 a.m.: 18 IR 245; filed Nov 16, 1995, 3:00 p.m.: 19 IR 664; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1083; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1515; errata filed Mar 21, 1997, 9:45 a.m.: 20 IR 2116; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 57; errata filed Jan 25, 2002, 2:27 p.m.: 25 IR 1906; filed Oct 20, 2003, 10:00 a.m.: 27 IR 863; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2249)*

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