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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #05-200

DIGEST

Amends 405 IAC 1-11.5-2 to allow for the reimbursement of services provided by certified physical therapists' assistants. Amends 405 IAC 5-22-8 to provide supervision requirements for services provided by certified physical therapists' assistants. Effective 30 days after filing with the Secretary of State.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

Small businesses that may be impacted by this rule change would consist of Medicaid providers that render physical therapy services to Medicaid recipients and bill on the medical claim format. This includes providers enrolled in Medicaid as licensed physical therapists or therapy clinics. The agency's Management Reporting System shows that, for calendar year 2004, there were 113 enrolled therapy clinics, of which 80 have participated (e.g., submitted claims for payment) in 2004. There are 229 enrolled physical therapists, of which 150 have participated in 2004. Thus, the rule is expected to impact an estimated 230 total small businesses.

There would be no reporting requirements imposed on providers associated with this rule change. There would be a very minor administrative impact on how providers complete claims for payment. If a physical therapy assistant provides the billed service rather than the physical therapist, the provider would need to add a modifier to the procedure code billed. This is the only administrative change. Providers would receive advance notice of this change and would receive written instructions on implementing the change.

This proposed rule also includes a slight reduction in Medicaid reimbursement for services rendered by physical therapy assistants. Assistants would be paid 75% of the allowance paid to a physical therapist performing the same service. This is in line with the reimbursement policy for other midlevel practitioners (for example, an enrolled nurse practitioner is paid 75% of the rate paid to a physician performing the same service). Currently services performed by a physical therapy assistant versus a licensed physical therapist are not identified. The agency can identify, however, the amount paid for physical therapy services. Based on calendar year 2004, approximately $600,000 was paid for physical therapy services billed on the medical claim form. Estimating that 25% of these services are performed by assistants would result in expenditures of $150,000. If the agency reduced payment for services performed by assistants by 25%, the total annual fiscal impact spread over all providers would be $37,500. Spreading the annual reduction across participating providers in 2004 (230) would result in an average annual impact of $163 per provider.

The proposed change in the physical therapy rule sprang from an issue that was raised by the Indiana Chapter of the American Physical Therapy Association regarding the discrepancy of supervision requirements between Medicaid's rule and the Medical Licensing Board's rule at 844 IAC 6-1-2(e) regarding physical therapy assistant (PTA) practice. The agency's rule was more restrictive, thus it is revised. Since the agency will now be identifying services performed by a physical therapy assistant, versus those performed by a licensed therapist, the reimbursement methodology was revised to pay physical therapy assistants 75% of the rate paid to therapists performing the same service. As indicated above, this is similar to the way the agency reimburses other midlevel practitioners (such as nurse practitioners).

The administrative and fiscal impacts to small businesses resulting from this rule are minor. It should be noted that the change in supervision requirements for physical therapy assistants could benefit providers, as it lifts the "onsite" supervision requirement, and equates to the direct supervision requirements that exist in the physical therapy practice rules found in 844 IAC 6.

405 IAC 1-11.5-2
405 IAC 5-22-8

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

405 IAC 1-11.5-2 Reimbursement methodology
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-13-2

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

(b) The reimbursement for services of physicians and LLPs shall be determined as follows:
(1) Reimbursement for services of physicians and LLPs, except services of the physicians in subdivisions (3) through (10), shall be equal to the lower of the following:
(A) The submitted charges for the procedure.
(B) The established fee schedule allowance for the procedure. The statewide established fee schedule allowance for the procedure is based on the Medicare relative value unit for an Indiana urban locality multiplied by the conversion factor for the procedure as established by the office of Medicaid policy and planning (office).
(2) If no Medicare relative value unit, as defined in this section, exists for a procedure, reimbursement will be established as follows:
(A) Relative value units may be:
(i) obtained from other state Medicaid programs; or ~~may be~~
(ii) developed specifically for the Indiana Medicaid program, subject to review by the Medicaid director.
(B) For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement will be made using the fee value in the national Medicare clinical laboratory fee schedule.
(3) The office may set reimbursement for specific procedure codes using a different methodology from that specified in subdivisions (1) and (2) in order to preserve access to the specific service.
(4) Reimbursement for services of anesthesiologists shall be based on a statewide fee schedule. The statewide fee schedule for anesthesiology services is based on the total base and time units for the procedure multiplied by the conversion factor as established by the office.
(5) Reimbursement for services of assistant surgeons shall be equal to twenty percent (20%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).
(6) Reimbursement for services of cosurgeons shall be paid at sixty-two and one-half percent (62.5%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).
(7) Reimbursement for services of physicians and LLPs shall be subject to the global surgery policy as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services. The global surgery policy will not apply to the following codes:
(A) 59410–Vaginal delivery, including postpartum care.
(B) 59515–Caesarean delivery, including postpartum care.
(8) Reimbursement for services of physicians and LLPs shall be subject to the policy for supplies and services incident to other procedures as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services.
(9) Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and in intra-arterial injections, if it is used for patients who meet the criteria established by the office.
(10) Reimbursement for services of physicians and LLPs shall be subject to the site of service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the statewide fee schedule for physician and LLP services as established under subdivision (1). These procedures are identified using the site of service indicator on the Medicare fee schedule database.

(c) Reimbursement for services of NPPs shall be in accordance with the following:
(1) Reimbursement for services of dentists in calendar year 1994 shall be based on a statewide fee schedule equal to a percentage of the fiscal year 1992 submitted charges. That percentage shall be no lower than the average percentage difference between physician and LLP submitted charges and the fee established for those services in accordance with subsection (b)(1). The office may set reimbursement for specific dental procedures using a different methodology from that specified in this subdivision in order to preserve access to the service. Beginning with the effective date of this revised rule, fees for covered dental services are priced at the levels in effect at the end of calendar year 1994, increased by a percentage determined by the office.
(2) Reimbursement for services of:
(A) social workers certified through the American Academy of Certified Social Workers (ACSW) or who have masters of social work (MSW) degrees;
(B) psychologists with basic certificates; and
(C) licensed psychologists;
providing outpatient mental health services in a physician-directed outpatient mental health facility in accordance with ~~405 IAC~~

~~1-6-13~~ ~~and~~ ~~405~~ ~~IAC~~ ~~1-7-20~~ **405 IAC 5-20-8** shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must continue to be billed through a physician or a physician-directed outpatient mental health facility.

(3) Reimbursement for services provided by independently practicing respiratory therapists and advance practice nurses shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1).

(4) Reimbursement for services provided by certified physical therapists' assistants shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must be billed through the supervising licensed physical therapist or physician.

~~(4)~~ **(5)** Reimbursement for services of all other NPPs shall be equal to the statewide fee schedule for physician and LLP services as established under subsection (b)(1).

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

(e) The relative value units used for the Indiana resource-based relative value scale fee schedule will be reviewed annually, taking into account the Medicare fee schedule proposed by the Health Care Financing Administration to take effect January 1 of the following calendar year and adjusted as necessary. *(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-2; filed Sep 6, 1994, 3:25 p.m.: 18 IR 88; errata filed Oct 18, 1994, 3:25 p.m.: 18 IR 532; filed Jun 21, 1995, 4:00 p.m.: 18 IR 2767; errata filed Sep 29, 1995, 1:30 p.m.: 19 IR 209; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 2. 405 IAC 5-22-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-8 Physical therapy services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 8. Physical therapy services are subject to the following restrictions:

(1) The physical therapy service must be performed by a licensed physical therapist or certified ~~therapist~~ **physical therapist's** assistant under the direct ~~on-site~~ supervision of a licensed physical therapist **or physician as defined in 844 IAC 6-1-2(e)** for reimbursement. Only the activities in this subdivision related to the therapy can be performed by someone other than a licensed therapist or certified ~~therapist~~ **physical therapist's** assistant who must be under the direct ~~on-site~~ supervision of a licensed physical therapist. Payment for the following services is included in the Medicaid allowance for the modality provided by the licensed therapist and may not be billed separately to Medicaid:

(A) Assisting patients in preparation for and, as necessary, during and at the conclusion of treatment.
(B) Assembling and disassembling equipment.
(C) Assisting the physical therapist in the performance of appropriate activities related to the treatment of the individual patient.
(D) Following established procedures pertaining to the care of equipment and supplies.
(E) Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas.
(F) Transporting:
(i) patients;
(ii) records;
(iii) equipment; and
(iv) supplies;
in accordance with established policies and procedures.
(G) Performing established clerical procedures.

(2) Certified physical therapists' assistants may provide services only under the direct supervision of a licensed physical therapist or physician as defined in 844 IAC 6-1-2(e).

~~(2)~~ **(3)** Evaluations and reevaluations are limited to three (3) hours of service per recipient evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include physical therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.

~~(3)~~ **(4)** Physical therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) hours, sessions, or visits in thirty (30) calendar days without prior authorization. This exception includes the provision of splints, crutches, and canes. Prior authorization must be obtained for additional services.

~~(4)~~ **(5)** Physical therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3341; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on November 22, 2005 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 22, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments concerning reimbursement for physical therapists' assistants' services.

In accordance with public notice requirements established at 42 CFR 447.205 and IC 4-22-2-24(d), the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning publishes this notice of proposed changes to the reimbursement methodology for physical therapy services.

This rule is being amended due to concerns raised by the Indiana Chapter of the American Physical Therapy Association that supervision requirements for certified physical therapists' assistants were more restrictive under Medicaid reimbursement rules than professional requirements under 844 IAC 6-1-2(e). Because services by an assistant are to be recognized, reimbursement methodology is amended to pay similarly to other midlevel practitioners.

It is estimated that the fiscal impact of these changes will result in an annual reduction of expenditures of state and federal dollars between approximately $19,000 and $95,000.

Copies of proposed amendments to the rules (405 IAC 1-11.5-2 and 405 IAC 5-22-8) are now available (along with copies of this public notice) and may be inspected by contacting the Director of the local County Division of Family Resources office, except in Marion County, where public inspection may be made at the Indiana Government Center-South, 402 West Washington Street, Room W382, Indianapolis, Indiana. Written comments may be directed to IFSSA, Attention: Kate Bowen, Indiana Government Center-South, 402 West Washington Street, Room W382, P.O. Box 7083, Indianapolis, Indiana 46207-7083. Correspondence should be identified in the following manner: "COMMENT RE: LSA DOCUMENT #05-220 PROPOSED CHANGES TO PHYSICAL THERAPY REIMBURSEMENT". Written comments received will be made available for public display at the address herein of the Office of Medicaid Policy and Planning.

Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

E. Mitchell Roob Jr.
Secretary
Office of the Secretary of Family and Social Services