§15113. Reimbursement Methodology

A. Effective for dates of service on or after October 15, 2007, the reimbursement for selected physician services shall be 90 percent of the 2007 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount, unless otherwise stipulated.

1. 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 2007 Louisiana Medicare Region 99 allowable.

2. For those services that are currently reimbursed at a rate above 120 percent of the 2007 Louisiana Medicare Region 99 allowable, effective for dates of service on or after October 15, 2007, the reimbursement for these services shall be reduced to 120 percent of the 2007 Louisiana Medicare Region 99 allowable.

B. 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.

1. 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.

2. 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.

C. 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.

1. For those services that are currently reimbursed at a rate below 80 percent of the Louisiana Medicare Region 99 allowable, effective for dates of service on or after August 4, 2009, the reimbursement for these services shall be increased to 80 percent of the Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

2. The following physician services are excluded from the rate adjustment:

a. preventive medicine evaluation and management;

b. immunizations;

c. family planning services; and

d. select orthopedic reparative services.

3. Effective for dates of service on or after November 20, 2009, the following physician services are excluded from the rate adjustment:

a. prenatal evaluation and management; and

b. delivery services.

D. Effective for dates of service on or after January 22, 2010, physician services rendered to recipients 16 years of age or older shall be reduced to 75 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

1. The following physician services rendered to recipients 16 years of age or older shall be reimbursed at 80 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount:

a. prenatal evaluation and management services;

b. preventive medicine evaluation and management services; and

c. obstetrical delivery services.

E. Effective for dates of service on or after January 22, 2010, physician services rendered to recipients 16 years of age or older shall be reduced to 75 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

F. Effective for dates of service on or after January 22, 2010, all physician-administered drugs shall be reimbursed at 90 percent of the 2009 Louisiana Medicare average sales price (ASP) allowable or billed charges, whichever is the lesser amount.

G. Effective for dates of service on or after January 22, 2010, all physician services that are currently reimbursed below the reimbursement rates in §15113.D-F shall be increased to the rates in §15113.D-F.

H. Effective for dates of service on or after December 1, 2010, reimbursement shall be 90 percent of the 2009 Louisiana Medicare Region 99 allowable for the following obstetric services when rendered to recipients 16 years of age and older:

1. vaginal-only delivery (with or without postpartum care);

2. vaginal delivery after previous cesarean (VBAC) delivery; and

3. cesarean delivery following attempted vaginal delivery after previous cesarean delivery. The reimbursement for a cesarean delivery remains at 80 percent of the 2009 Louisiana Medicare Region 99 allowable when the service is rendered to recipients 16 years of age and older.

I. 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 the rates on file as of June 30, 2012.

J. Effective for dates of service on or after January 1, 2013 through December 31, 2014, certain physician services shall be reimbursed at payment rates consistent with the methodology that applies to such services and physicians under part B of title XVIII of the Social Security Act (Medicare).

1. The following physician service codes, when covered by the Medicaid Program, shall be reimbursed at an increased rate:

a. evaluation and management codes 99201 through 99499; or

b. their successor codes as specified by the U.S. Department of Health and Human Services.

2. Qualifying Criteria. Reimbursement shall be limited to specified services furnished by or under the personal supervision of a physician, either a doctor of osteopathy or a medical doctor, who attests to a specialty or subspecialty designation in family medicine, general internal medicine or pediatrics, and who also attests to meeting one or more of the following criteria:

a. certification as a specialist or subspecialist in family medicine, general internal medicine or pediatric medicine by the American Board of Medical Specialists (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA); or

b. specified evaluation and management and vaccine services that equal at least 60 percent of total Medicaid codes paid during the most recently completed calendar year, or for newly eligible physicians the prior month.

3. Payment Methodology. For primary care services provided in calendar years 2013 and 2014, the reimbursement shall be the lesser of the:

a. Medicare Part B fee schedule rate in calendar years 2013 or 2014 that is applicable to the place of service and reflects the mean value over all parishes (counties) of the rate for each of the specified or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor multiplied by the calendar year 2013 and 2014 relative value units in accordance with 42 CFR 447.405. If there is no applicable rate established by Medicare, the reimbursement shall be the rate specified in a fee schedule established and announced by the Centers for Medicare and Medicaid Services (CMS); or

b. provider's actual billed charge for the service.

4. The department shall make payment to the provider for the difference between the Medicaid rate and the increased rate, if any.

K. 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.

L. 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 a similar service.

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.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1252 (June 2010), amended LR 36:2282 (October 2010), LR 37:904 (March 2011), LR 39:3300, 3301 (December 2013), LR 41:541 (March 2015), LR 41:1119 (June 2015), LR 41:1291 (July 2015).