Fee Schedule Rates for Free Standing Clinic Services, Ambulatory Surgical Centers, and Outpatient Hospital Services are the same for governmental and private providers except as otherwise noted in the Plan. The agency's fee schedule rates were set on various dates and are in effect for services provided on or after April 1, 2010. All rates and effective dates are published on the agency's website at www.indianamedicaid.com.

CLINIC SERVICES

FREE STANDING CLINIC SERVICES

The Office of Medicaid Policy and Planning (OMPP), in accordance with 42 CFR 447.325, will not pay more than the prevailing charges in the locality for comparable services under comparable circumstances. Freestanding clinic services are reimbursed on a fee for service basis according to the Indiana Medicaid fee schedule rates.

AMBULATORY SURGICAL CENTERS

As applicable, services provided by free-standing Ambulatory Surgical Centers (ASC) are reimbursed in accordance with outpatient hospital services as described below.

OUTPATIENT HOSPITAL SERVICES

The reimbursement methodology for all covered outpatient hospital 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. Services shall be billed in accordance with provider manuals and update bulletins.

(a) Reimbursement for outpatient surgical procedures performed in a hospital or provider-based ambulatory surgical center will be based on the Indiana Medicaid statewide allowed amounts for that service. 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. The Office of Medicaid Policy and Planning will classify outpatient surgical procedures not classified into an ASC group by Medicare into one of the nine (9) ASC groups designated by Medicare, or additional payment groups.

(b) Payments for provider-based emergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the 2003 statewide fee schedule amounts for services provided on or after April 1, 2004.

(c) Payments for provider-based non-emergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the 2003 statewide fee schedule amounts for services provided on or after April 1, 2004.

(d) The fixed fees for laboratory procedures are based on the Medicare fee schedule amounts and are paid on a per test basis. The fee schedule rate for each laboratory procedure does not exceed the current Medicare fee schedule amount. Reimbursement for the technical component of radiology procedures shall be based on the Indiana Medicaid physician fee schedule amounts for the technical component of radiology services.

(e) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., will be based on the 2003 Indiana Medicaid statewide fee schedule amounts for services provided on or after April 1, 2004.

(f) Payments will not be made for outpatient hospital 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.

The established rates for hospital outpatient reimbursement shall be reviewed annually by the Office of Medicaid Policy and Planning and adjusted no more frequently than every second year and in accordance with this section to ensure that revisions contain appropriate incentives for provision of primary and preventive care.