

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:

CITATION **Medical and Remedial Clinic Services (Other than Hospitals) are reimbursed as follows:**
42 CFR 447 Care and Services
Subpart F Item 9

I. **Method of Payment**

A. **Mental Health Clinics, Family Planning Clinics, End Stage Renal Disease Facilities, and Radiation Therapy Centers.**

- (1) **Payment to public mental health clinics is made for these services on the basis of costs.**

Payment to family planning clinics is made at the same prospective fee for service as authorized for Physicians and other provider services covered under the plan. For those services not covered elsewhere in the plan, payment is based on 1987 audited costs determined to be reasonable. Reimbursement for services provided under this section shall be adjusted to reflect any rate increase granted under Physician and other provider services covered under the plan. Those services not covered elsewhere in the plan shall be limited to the average cost granted for other similar services provided under this section.

Effective for dates of service on or after August 1, 2010, the reimbursement rates for family planning clinic services shall be 75 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount minus any third party liability coverage.

Effective for dates of service on or after July 1, 2012, the reimbursement rates for family planning clinics shall be equal to the reimbursement rates for family planning services in the Professional Services Program.

- (2) **Payment to private mental health clinics is based on charges not to exceed a reasonable rate set by the State. Governmental clinic cost data will be used as one of the determinants of forming a basis to establish rates for private clinics. Charge data will also be a factor in rate determination.**

Governmental mental health clinics are reimbursed a daily state-wide encounter rate established 1/1/2004 based on costs using Medicaid cost reporting guidelines.

TN# 12-40
Supersedes
TN# 10-46

Approval Date 9/27/13
Effective Date: 7/1/12

State: Louisiana
Date Received: 27 July, 2012
Date Approved: 27 September 2013
Date Effective: 1 July, 2012
Transmittal Number: LA 12-40

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- (3) Payment to freestanding end stage renal disease (ESRD) facilities and radiation therapy centers.
 - (a) ESRD Facilities
 - (i) For non-Medicare claims, end stage renal disease (ESRD) facilities are reimbursed a hemodialysis composite rate. The composite rate is a comprehensive payment for the complete hemodialysis treatment in which the facility assumes responsibility for providing all medically necessary routine dialysis services.

Covered non-routine dialysis services, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), epogen (EPO) and injectable drugs are reimbursed separately from the composite rate.

Effective for dates of service on or after October 20, 2020, covered non-routine laboratory services may be billed by either the ESRD facility or the facility's contracted outside laboratory.

Effective for dates of service on or after February 26, 2009, the reimbursement to ESRD facilities shall be reduced by 3.5 percent of the rates in effect on February 25, 2009.

Effective for dates of service on or after January 22, 2010, the reimbursement to ESRD facilities shall be reduced by 5 percent of the rates in effect on January 21, 2010.

Effective for dates of service on or after August 1, 2010, the reimbursement to ESRD facilities shall be reduced by 4.6 percent of the rates in effect on July 31, 2010.

Effective for dates of service on or after January 1, 2011, the reimbursement to ESRD facilities shall be reduced by 2 percent of the rates in effect on December 31, 2010.

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Effective for dates of service on or after July 1, 2012, the reimbursement to ESRD facilities shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

- (ii) For Medicare Part B claims, ESRD facilities are reimbursed for full co-insurance and deductibles.

The Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

Effective for dates of service on or after February 26, 2009, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 3.5 percent of the rates in effect on February 25, 2009.

Effective for dates of service on or after January 22, 2010, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 5 percent of the rates in effect on January 21, 2010.

Effective for dates of service on or after August 1, 2010, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 4.6 percent of the rates in effect on July 31, 2010.

Effective for dates of service on or after January 1, 2011, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 2 percent of the rates in effect on December 31, 2010.

Effective for dates of service on or after July 1, 2012, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

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:

(b) Radiation Therapy Centers.

Radiation Therapy Centers are reimbursed fee for service according to the procedure code. Reimbursement of radiation therapy center services shall be the lower of billed charges or the fee on file, minus the amount which any third party coverage would pay. These services are included on the professional services fee schedule which was set as of January 1, 2008 and is published on the agency's provider website at www.lamedicaid.com.

Effective for dates of service on or after February 26, 2009, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

Effective for dates of service on or after August 4, 2009, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 4.7 percent of the fee amounts on file as of August 3, 2009.

Effective for dates of service on or after January 22, 2010, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 4.42 percent of the fee amounts on file as of January 21, 2010.

Effective for dates of service on or after August 1, 2010, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

Effective for dates of service on or after January 1, 2011, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

Effective for dates of service on or after July 1, 2012, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 3.7 percent of the fee amount on file as of June 30, 2012.

Effective for dates of service on or after May 20, 2014 the reimbursement for radiology services provided by radiation therapy centers shall be based on usual and customary billed charges or the Medicaid fee on file as of May 19, 2014, whichever is lesser. If radiology services provided by radiation therapy centers do not have Medicare established rates, fees will be based on review of statewide billed charges for that service in comparison with set charges for similar services. If there is no similar service, fees are based upon consultant physicians' review and recommendations. Reimbursement shall be the lesser of the billed charges or the Medicaid fee on file.

TN# 14-21 Approval Date 07-30-14 Effective Date 05-20-14
Supersedes
TN# 12-46

State: Louisiana
Date Received: 9 June, 2014
Date Approved: 30 July, 2014
Date Effective: 20 May, 2014
Transmittal Number: 14-21

STATE OF LOUISIANA

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

Citation MEDICAL AND REMEDIAL
42 CFR CARE AND SERVICES
447.352 Item 9 (Continued)

- (4) Louisiana Medical Assistance Program uses a statewide flat fee-for-service reimbursement methodology for services provided by prenatal health care clinics.

Determination of flat-fee amounts was based on review of 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 Medical Assistance 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, service 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.

STATE	LA	A
DATE REC'D	11 5 1988	
DATE APP'VD	JAN 25 1989	
DATE EFF	OCT 1 1988	
HC-174	88-26	

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:

TN# 88-26 Approval Date JAN 25 1989 Effective Date OCT 01 1988
Supersedes
TN# 87-12 pay 1a

STATE OF LOUISIANA

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Citation MEDICAL AND REMEDIAL
42 CFR CARE AND SERVICES
447.352 Item 9 (Continued)

The Medical Assistance 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, service and procedure that do not have charges set by the Medicare contractor, the Medical Assistance 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 Medical assistance 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. Providers are advised to bill usual and customary charges in order for the Agency to continue to use these charges to establish prevailing fees in Louisiana.

STATE	<u>LA</u>	A
DATE RECD	<u>1988</u>	
DATE APPLD	<u>JAN 25 1989</u>	
DATE EFF	<u>OCT 01 1988</u>	
HCPC 179	<u>88-26</u>	

B. Ambulatory Surgical Centers

Payment is made on a flat fee basis to ambulatory surgical centers. Certain outpatient surgeries are reimbursed a flat fee per service/occurrence in accordance with

TN# 88-26 Approval Date JAN 25 1989 Effective Date OCT 01 1988
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 TN# 87-12 page 1b

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<u>CITATION</u> 42 CFR 447 Subpart F	Medical and Remedial Care and Services Item 9 (cont'd.)	four groupings, not to exceed the Medicare maximums for ambulatory surgeries. Surgeries not included in these groupings continue to be reimbursed at the State's flat fee amount.
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The flat fee amounts for the four groupings and the State's flat fee amount cover all operative functions attendant to medically necessary surgery performed at the center by a private physician, osteopathic physician, or dentist (for emergency and life threatening conditions and for EPSDT eligibles) including admitting and laboratory tests, patient history and physical, operating room staffing and attendants, recovery room charges and discharge, except for those certain procedures that have been identified as having a separate reimbursement. It includes all supplies related to the surgical care of the patient while in the center. The flat fee payment excludes the physician fee, the radiologist fee, or the anesthesiology fee for private physicians not under contract to the Center as well as any prosthetic devices related to the surgery which must be billed separately.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any adjustments to the fee schedule are published on the agency's provider website at www.lamedicaid.com. The agency's fee schedule rate was set as of December 1, 1985 and is effective for services provided on or after that date. All rates are published on the agency's website.

Effective for dates of service on or after February 26, 2009, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 3.5 percent of the rate in effect on February 25, 2009.

Effective for dates of service on or after February 5, 2010, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 5 percent of the rate in effect on February 4, 2010.

Effective for dates of service on or after August 1, 2010, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 4.4 percent of the fee amounts on file as of July 31, 2010.

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Effective for dates of service on or after January 1, 2011, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

Effective for dates of service on or after July 1, 2012, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

Effective for dates of service on or after September 20, 2021, reimbursement for COVID-19 laboratory testing shall be made, in addition to the ambulatory surgical center flat fee reimbursement amount.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of COVID-19 laboratory testing in ambulatory surgical centers. The agency's fee schedule rate was set as of June 17, 2021, and is effective for services provided on or after that date. All rates are published on the Louisiana Medicaid website at www.lamedicaid.com.

Effective for dates of service after March 20, 2024, an ambulatory surgical center shall be reimbursed based on the Louisiana Medicaid Louisiana State University (LSU) ambulatory surgical center fee schedule rate if the ambulatory surgical center is:

1. owned and/or operated by LSU School of Dentistry, LSU Health Sciences Center, or LSU Healthcare network;
2. licensed within the state of Louisiana; and
3. Medicaid enrolled.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of ambulatory surgical center services. The agency's fee schedule rate was set as of January 1, 2024, and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com.

C. Tuberculosis (TB) and Sexually Transmitted Disease (STD) Control Clinics

Effective for services on or after October 1, 2003, TB and STD clinics are reimbursed according to fee schedule amounts which in the aggregate are less than or equal to the Medicare payment

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Medical and Remedial Care and Services
Item 9
Clinic Services (Continued)

II. Standards for Payment

- A. "Clinic services" are diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a physician in a facility which is not part of a hospital but which is organized and operated to provide medical care to patients.

Mental health clinics must meet the standards for psychiatric facilities providing clinic services as determined by the Bureau of Health Services Financing, Health Standards Section. ESRD facilities must meet the Title XVIII qualifications and be Medicare certified as free-standing end stage renal disease facilities. Radiation therapy centers must adhere to all federal and state laws governing radiation control.

- B. "Ambulatory Surgical Centers services" must be medically necessary, diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a physician, osteopathic physician or dentist (for emergency and life threatening conditions and for EPSDT eligibles) in a facility which is not part of a hospital but which is organized and operated to provide medical care to patients. Ambulatory Surgical Centers (ASC) are free-standing facilities. These facilities do not provide services or other accommodations for patients that

SUPERSEDES: TN- 00-13

STATE <u>Louisiana</u>	A
DATE REC'D <u>3-30-09</u>	
DATE APPV'D <u>12-14-09</u>	
DATE EFF. <u>2-26-09</u>	
HCFA 179 <u>09-15</u>	

TN# 09-15 Approval Date 12-14-09 Effective Date 2-26-09
Supersedes

TN# 00-13

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Citation Medical and Remedial Clinic Services (Other than Hospitals)
Care and Services

42 CFR
447.352

Item 9 (Cont.)

stay overnight. Therefore, the Ambulatory Surgical Centers shall have a system to transfer patients requiring emergency admittance or overnight care to a fully licensed and certified Title XIX hospital following any surgical procedure performed at the facility.

Prenatal Health Care, Tuberculosis (TB) and Sexually Transmitted Disease (STD) Control Clinics must meet the requirements of 42 CFR 440.90 and are subject to the same standards as physicians participating in Title XIX reimbursement.

For obstetrical and pediatric codes and applicable rates, see Item 5.

STATE <u>LA</u>	A
DATE REC'D <u>3-30-90</u>	
DATE APP'VD <u>5-30-90</u>	
DATE EFF <u>4-1-90</u>	
HCFA 179 <u>90-9</u>	

TN# 90-9 Approval Date 5-30-90 Effective Date 4-1-90
 Supersedes
 TN# 88-26