TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #15-418

DIGEST

Amends 405 IAC 1-10.5-1, 405 IAC 1-10.5-2, 405 IAC 1-10.5-3, 405 IAC 5-1-5, 405 IAC 5-2-13, 405 IAC 5-3-5, and 405 IAC 5-3-6 to modify the Medicaid reimbursement rule for covered inpatient hospital services due to the implementation of the International Classification of Diseases 10th Revision (ICD-10) diagnosis and procedure codes, the adoption of a new diagnosis related group (DRG) classification and payment system, and the rebasing of inpatient hospital rates, and to make technical changes. Amends 405 IAC 1-1-1 to update and modify definitions to provide uniformity in terminology used throughout the articles and to reflect current terms used in practice. Amends 405 IAC 1-1-2, 405 IAC 1-1-3, 405 IAC 1-1-13, 405 IAC 1-1-14, 405 IAC 1-1-15, 405 IAC 1-1-16, 405 IAC 1-1.6-1, 405 IAC 1-3-2, 405 IAC 1-4.2-1, 405 IAC 1-4.2-2, 405 IAC 1-4.2-3, 405 IAC 1-4.2-3.1, 405 IAC 1-4.2-4, 405 IAC 1-4.2-6, 405 IAC 1-4.3-1, 405 IAC 1-8-2, 405 IAC 1-8-3, 405 IAC 1-8-4, 405 IAC 1-10.5-4, 405 IAC 1-11.5-1, 405 IAC 1-11.5-2, 405 IAC 1-11.5-3, 405 IAC 1-12-1, 405 IAC 1-12-2, 405 IAC 1-12-3, 405 IAC 1-12-4, 405 IAC 1-12-5, 405 IAC 1-12-7, 405 IAC 1-12-9, 405 IAC 1-12-15, 405 IAC 1-12-19, 405 IAC 1-12-21, 405 IAC 1-12-22, 405 IAC 1-12-23, 405 IAC 1-12-24, 405 IAC 1-12-25, 405 IAC 1-12-26, 405 IAC 1-12-27, 405 IAC 1-13-1, 405 IAC 1-13-2, 405 IAC 1-14.6-1, 405 IAC 1-14.6-2, 405 IAC 1-14.6-3, 405 IAC 1-14.6-4, 405 IAC 1-14.6-5, 405 IAC 1-14.6-6, 405 IAC 1-14.6-7, 405 IAC 1-14.6-9, 405 IAC 1-14.6-10, 405 IAC 1-14.6-16, 405 IAC 1-14.6-19, 405 IAC 1-14.6-20, 405 IAC 1-14.6-22, 405 IAC 1-14.6-24, 405 IAC 1-15-1, 405 IAC 1-15-2, 405 IAC 1-15-3, 405 IAC 1-15-5, 405 IAC 1-16-1, 405 IAC 1-16-2, 405 IAC 1-16-3, 405 IAC 1-16-4, 405 IAC 1-16-5, 405 IAC 1-17-1, 405 IAC 1-17-2, 405 IAC 1-17-4, 405 IAC 1-17-7, 405 IAC 1-17-17, 405 IAC 1-17-18, 405 IAC 1-18-2, 405 IAC 1-19-2, 405 IAC 1-20-1, 405 IAC 1-20-2, 405 IAC 1-20-4, 405 IAC 1-21-1, 405 IAC 1-21-3, and 405 IAC 1-21-4 to reflect the definitions updates. Amends 405 IAC 5-2-3, 405 IAC 5-2-6, 405 IAC 5-2-9, 405 IAC 5-2-12, 405 IAC 5-2-13.2, 405 IAC 5-2-15, 405 IAC 5-2-16, 405 IAC 5-2-17, 405 IAC 5-2-18, 405 IAC 5-2-19, 405 IAC 5-2-20, 405 IAC 5-2-21, 405 IAC 5-2-22, and 405 IAC 5-2-24 and adds 405 IAC 5-2-10.5, 405 IAC 5-2-11.5, 405 IAC 5-2-15.5, 405 IAC 5-2-17.5, and 405 IAC 5-2-29 to update and modify definitions to provide uniformity in terminology used throughout the articles and to reflect current terms used in practice. Amends 405 IAC 5-1-1, 405 IAC 5-1-2, 405 IAC 5-1-3, 405 IAC 5-1-4, 405 IAC 5-1-6, 405 IAC 5-3-1, 405 IAC 5-3-2, 405 IAC 5-3-7, 405 IAC 5-3-8, 405 IAC 5-3-9, 405 IAC 5-3-11, 405 IAC 5-3-12, 405 IAC 5-3-13, 405 IAC 5-3-14, 405 IAC 5-5-2, 405 IAC 5-5-3, 405 IAC 5-6-1, 405 IAC 5-6-2, 405 IAC 5-7-1, 405 IAC 5-7-2, 405 IAC 5-7-3, 405 IAC 5-8-2, 405 IAC 5-8-3, 405 IAC 5-8-4, 405 IAC 5-9-1, 405 IAC 5-9-2, 405 IAC 5-10-1, 405 IAC 5-10-3, 405 IAC 5-12-1, 405 IAC 5-12-2, 405 IAC 5-12-3, 405 IAC 5-13-1, 405 IAC 5-13-2, 405 IAC 5-13-3, 405 IAC 5-13-6, 405 IAC 5-13-7, 405 IAC 5-13-8, 405 IAC 5-13-10, 405 IAC 5-14-1, 405 IAC 5-14-2, 405 IAC 5-14-3, 405 IAC 5-14-4, 405 IAC 5-14-5, 405 IAC 5-14-6, 405 IAC 5-14-7, 405 IAC 5-14-15, 405 IAC 5-14-18, 405 IAC 5-14-19, 405 IAC 5-14-20, 405 IAC 5-14-21, 405 IAC 5-15-1, 405 IAC 5-15-2, 405 IAC 5-15-3, 405 IAC 5-15-4, 405 IAC 5-15-6, 405 IAC 5-16-1, 405 IAC 5-16-3, 405 IAC 5-16-3.1, 405 IAC 5-16-5, 405 IAC 5-16-6, 405 IAC 5-16.5-1, 405 IAC 5-16.5-2, 405 IAC 5-16.5-3, 405 IAC 5-16.5-4, 405 IAC 5-17-1, 405 IAC 5-17-2, 405 IAC 5-17-4, 405 IAC 5-17-5, 405 IAC 5-18-4, 405 IAC 5-19-1, 405 IAC 5-19-2, 405 IAC 5-19-3, 405 IAC 5-19-4, 405 IAC 5-19-5, 405 IAC 5-19-6, 405 IAC 5-19-7, 405 IAC 5-19-8, 405 IAC 5-19-9, 405 IAC 5-19-12, 405 IAC 5-19-13, 405 IAC 5-19-14, 405 IAC 5-19-15, 405 IAC 5-19-16, 405 IAC 5-19-17, 405 IAC 5-19-18, 405 IAC 5-20-1, 405 IAC 5-20-2, 405 IAC 5-20-3, 405 IAC 5-20-4, 405 IAC 5-20-5, 405 IAC 5-20-8, 405 IAC 5-21.5-1, 405 IAC 5-21.5-2, 405 IAC 5-21.5-3, 405 IAC 5-21.5-4, 405 IAC 5-21.5-5, 405 IAC 5-21.5-6, 405 IAC 5-21.5-7, 405 IAC 5-21.5-8, 405 IAC 5-21.5-9, 405 IAC 5-21.5-10, 405 IAC 5-21.5-11, 405 IAC 5-21.5-12, 405 IAC 5-21.5-13, 405 IAC 5-21.5-14, 405 IAC 5-21.5-15, 405 IAC 5-21.5-17, 405 IAC 5-21.6-2, 405 IAC 5-21.6-3, 405 IAC 5-21.6-4, 405 IAC 5-21.6-5, 405 IAC 5-21.6-6, 405 IAC 5-21.6-7, 405 IAC 5-21.6-8, 405 IAC 5-21.6-9, 405 IAC 5-21.6-10, 405 IAC 5-21.6-11, 405 IAC 5-21.6-12, 405 IAC 5-21.6-13, 405 IAC 5-21.6-14, 405 IAC 5-21.6-15, 405 IAC 5-21.6-16, 405 IAC 5-21.6-17, 405 IAC 5-21.6-18, 405 IAC 5-21.6-19, 405 IAC 5-21.7-1, 405 IAC 5-21.7-2, 405 IAC 5-21.7-3, 405 IAC 5-21.7-4, 405 IAC 5-21.7-5, 405 IAC 5-21.7-6, 405 IAC 5-21.7-7, 405 IAC 5-21.7-8, 405 IAC 5-21.7-9, 405 IAC 5-21.7-10, 405 IAC 5-21.7-11, 405 IAC 5-21.7-12, 405 IAC 5-21.7-13, 405 IAC 5-21.7-14, 405 IAC 5-21.7-15, 405 IAC 5-21.7-16, 405 IAC 5-21.7-17, 405 IAC 5-21.7-18, 405 IAC 5-21.7-19, 405 IAC 5-21.7-20, 405 IAC 5-21.7-21, 405 IAC 5-21.8-2, 405 IAC 5-21.8-3, 405 IAC 5-21.8-4, 405 IAC 5-21.8-5, 405 IAC 5-21.8-6, 405 IAC 5-21.8-7, 405 IAC 5-21.8-8, 405 IAC 5-21.8-9, 405 IAC 5-21.8-10, 405 IAC 5-21.8-11, 405 IAC 5-22-1, 405 IAC 5-22-2, 405 IAC 5-22-6, 405 IAC 5-22-7, 405 IAC 5-22-8, 405 IAC 5-22-9, 405 IAC 5-22-10, 405 IAC 5-22-11, 405 IAC 5-23-2, 405 IAC 5-23-3, 405 IAC 5-23-4, 405 IAC 5-24-1, 405 IAC 5-24-3, 405 IAC 5-24-4, 405 IAC 5-24-6, 405 IAC 5-24-7, 405 IAC 5-24-9, 405 IAC 5-24-13, 405 IAC 5-25-1, 405 IAC 5-25-2, 405 IAC 5-25-4, 405 IAC 5-26-5, 405 IAC 5-26-6, 405 IAC 5-26-7, 405 IAC 5-26-10, 405 IAC 5-27-1, 405 IAC 5-28-1, 405 IAC 5-28-4, 405 IAC 5-28-5, 405 IAC 5-28-8, 405 IAC 5-28-9, 405 IAC 5-29-1, 405 IAC 5-30-1, 405 IAC 5-30-2, 405 IAC 5-30-3, 405 IAC 5-30-4, 405 IAC 5-30-5, 405 IAC 5-30-6, 405 IAC 5-30-7, 405 IAC 5-30-8, 405 IAC 5-30-9, 405 IAC 5-30-10, 405 IAC 5-31-1, 405 IAC 5-31-1.1, 405 IAC 5-31-4, 405 IAC 5-31-

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

405 IAC 1-1-1; 405 IAC 1-1-2; 405 IAC 1-1-3; 405 IAC 1-1-13; 405 IAC 1-1-14; 405 IAC 1-1-15; 405 IAC 1-1-16; 405 IAC 1-1.6-1; 405 IAC 1-3-2; 405 IAC 1-4.2-1; 405 IAC 1-4.2-2; 405 IAC 1-4.2-3; 405 IAC 1-4.2-3.1; 405 IAC 1-4.2-4; 405 IAC 1-4.2-6; 405 IAC 1-4.3-1; 405 IAC 1-8-2; 405 IAC 1-8-3; 405 IAC 1-8-4; 405 IAC 1-10.5-1; 405 IAC 1-10.5-2; 405 IAC 1-10.5-3; 405 IAC 1-10.5-4; 405 IAC 1-11.5-1; 405 IAC 1-11.5-2; 405 IAC 1-11.5-3; 405 IAC 1-12-1; 405 IAC 1-12-2; 405 IAC 1-12-3; 405 IAC 1-12-4; 405 IAC 1-12-5; 405 IAC 1-12-7; 405 IAC 1-12-9; 405 IAC 1-12-15; 405 IAC 1-12-19; 405 IAC 1-12-21; 405 IAC 1-12-22; 405 IAC 1-12-23; 405 IAC 1-12-24; 405 IAC 1-12-25; 405 IAC 1-12-26; 405 IAC 1-12-27; 405 IAC 1-13-1; 405 IAC 1-13-2; 405 IAC 1-14.6-1; 405 IAC 1-14.6-2; 405 IAC 1-14.6-3; 405 IAC 1-14.6-4; 405 IAC 1-14.6-5; 405 IAC 1-14.6-6; 405 IAC 1-14.6-7; 405 IAC 1-14.6-9; 405 IAC 1-14.6-10; 405 IAC 1-14.6-16; 405 IAC 1-14.6-19; 405 IAC 1-14.6-20; 405 IAC 1-14.6-22; 405 IAC 1-14.6-24; 405 IAC 1-15-1; 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SECTION 1. 405 IAC 1-1-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1-1 Definitions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-6-10; IC 12-13-7-3; IC 12-15; IC 16-19; IC 16-21; IC 16-28; IC 16-29-4-2

Sec. 1. (a) ~~"Medical assistance" and "Medicaid" are used synonymously, and mean payment to or on behalf of part or all of the cost of medical or remedial services on behalf of eligible needy individuals as defined in IC 12-1-7-14.9.~~ **The definitions in this section apply throughout this article.**

(b) "Attending physician" means a physician who is responsible for developing and maintaining the plan of care for a Medicaid patient.

(c) ~~"Provider" means an individual, state or local agency, corporate, or business entity which meets the requirements of 470 IAC 5-8-4.~~ **"CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the United States Department of Health and Human Services.**

(d) ~~"Department" or "state department" means the state department of public welfare.~~ **"CRF/DD" or "CRFs/DD" means a community residential facility or facilities for the developmentally disabled.**

(e) ~~"Contractor" means the entity which makes payment to Medicaid providers under a contract with the department pursuant to IC 12-1-7-17.1.~~ **"CRMNF" means a comprehensive rehabilitative management needs facility as defined in 460 IAC 9-1-2.**

(f) ~~"Third party" means an insurer, individual, institution, corporation, public or private agency who is or may be liable to pay all or part of the medical costs of injury, disease or disability of an applicant or recipient of Medicaid.~~ **"ICF/IID" or "ICFs/IID" means an institution or institutions for individuals with intellectual disabilities, as described in IC 16-29-4-2, or a medical institution or that portion thereof providing such care, which is qualified as such an institution pursuant to the provisions of Title XIX of the Social Security Act.**

(g) ~~"Parameter" means the maximum amount and/or duration or a service within appropriate limits for which payment may be made without prior authorization or exception due to medical necessity or contra-indications.~~ **"IMFCU" means the Medicaid fraud control unit established by the Indiana attorney general under the authority of IC 4-6-10 et seq.**

(h) ~~"Provider manual" means the interpretive document(s) issued by the state department to providers to inform them of their obligations under the Medicaid program to which they must conform to retain their provider status and receive payment for appropriate services, and to provide them essential information for understanding the Medicaid program as it relates to the services for which they are qualified to provide under the state statutes.~~ **"ISDH" means the Indiana state department of health as defined in IC 16-19.**

(i) ~~"Nursing home care" means in-patient care and services provided by nursing homes, also identified as long-term care facilities, licensed under Indiana law and certified as meeting Medicaid standards of care to provide one (1) of two (2) levels of care as described in 470 IAC 5-3 the Indiana's Medicaid Program Criteria for Level of Care by Long-Term Care Facilities, such levels of care being identified as skilled level of care and intermediate level of care.~~ **"Medicaid" means that program described by IC 12-15 and this title, in which the office administers benefits and makes payments to providers for covered services provided to members.**

(j) ~~"Intermediate care for the mentally retarded" means care provided by an institution for the mentally retarded or a medical institution which institution or that portion thereof providing such care qualified as an intermediate care facility for the mentally retarded pursuant to the provisions of Title XIX of the Social Security Act.~~ **"Member" means an individual who has been determined by the office to be eligible for payment of covered services pursuant to IC 12-15.**

(k) ~~The pronoun "he" when used herein refers to the feminine as well as to the masculine gender.~~ **"Nursing**

facility" means a comprehensive care facility licensed under IC 16-28, or a hospital based long term care facility licensed under IC 16-21 and enrolled as a Medicaid provider.

(l) "Nursing facility services" has the meaning set forth in 405 IAC 5-31-1.1.

(m) "Office" means the Indiana family and social services administration and its offices, divisions, or designees.

(n) "Parameter" means the maximum amount or duration, or both, of a service within appropriate limits for which payment may be made without prior authorization or exception due to medical necessity or contraindications.

(o) "Prior authorization" has the meaning set forth in 405 IAC 5-2-20.

(p) "Provider" means an individual, state agency, local agency, corporate entity, or business entity that has been enrolled in Medicaid pursuant to 405 IAC 5-4.

(q) "Provider manual" means the interpretive document or documents issued by the office to providers to inform them of their obligations under Medicaid to which they must conform to retain their provider status and receive payment for appropriate services, and to provide them essential information for understanding Medicaid as it relates to the services for which they are qualified to provide under the state statutes.

(r) "Third party" means an insurer, individual, institution, corporation, or public or private agency who is or may be liable to pay all or part of the medical costs of injury, disease, or disability of an applicant or recipient of Medicaid.

(s) "Usual and customary charge" means the amount a provider offers to charge the general public for a service or supply, including applicable offered discounts. General public does not include individuals who are enrolled in or a member of an insurance plan that covers the services or supplies in question, or receive a discount of the services or supplies through a program with selective criteria that disqualify certain individuals from eligibility in the program.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-101; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 248; filed Sep 29, 1982, 3:19 p.m.: 5 IR 2321; filed Mar 14, 1986, 4:35 p.m.: 9 IR 1856; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-1) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

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

405 IAC 1-1-2 Choice of provider and use of Medicaid card

Authority: IC 12-13; IC 12-15
Affected: IC 12-13-2-3; IC 12-13-7-3; IC 12-15-12; IC 12-15-28-1

Sec. 2. (a) The ~~recipient~~ **member** shall have free choice of providers for services provided in the state of Indiana and for services provided outside the state on an emergency basis, except as provided in subsections (b) through (c). Services to be provided outside the state, except for those out-of-state areas that have been designated by the office, ~~of Medicaid policy and planning (office),~~ which are not of an emergency nature, require prior ~~approval~~ **authorization** of the office.

(b) In the event the office implements a managed care program, the ~~recipient~~ **member** shall select a managed care provider who is responsible for coordinating the ~~recipient's~~ **member's** health care needs. If a ~~recipient~~ **member** fails to select a managed care provider within a reasonable time after being furnished a list of managed care providers by the office, the office shall assign a managed care provider to the ~~recipient.~~ **member.** A Medicaid

~~recipient~~ **member** may not receive services from a provider other than the designated managed care provider except in the following cases:

(1) Medical emergencies.

(2) Where the managed care provider has authorized referral services in writing.

(3) Where specific services are excluded from coverage under the managed care program.

(4) Where specific services covered under the managed care program can be accessed through self-referral by ~~recipients,~~ **members,** as designated in IC 12-15-12 et seq.

(c) In the event that the office determines that a Medicaid ~~recipient~~ **member** has utilized any Medicaid coverage service or supply at a frequency or amount not medically ~~reasonable or~~ necessary, the office may restrict the benefits available to the Medicaid ~~recipient~~ **member** for a period of two (2) years by noting any restrictions on the face of the ~~recipient's~~ **member's** Medicaid card. The office may restrict the Medicaid ~~recipient's~~ **member's** benefits by:

(1) requiring that the ~~recipient~~ **member** only receive benefits from the provider or providers noted on the Medicaid card, except as specifically approved in advance by the office; or

(2) prohibiting the ~~recipient~~ **member** from receiving:

(A) any specific services noted on the card; or

(B) services from any specific provider or providers noted on the card.

(d) Not later than two (2) years after a Medicaid ~~recipient's~~ **member's** benefits have been restricted, the office will review the Medicaid ~~recipient's~~ **member's** case and continue the Medicaid ~~recipient's~~ **member's** restricted benefits if review of documented services indicates continued misutilization of Medicaid coverage services or supplies. The continued period of restriction will again be for a period of two (2) years, after which the Medicaid ~~recipient's~~ **member's** case will be reviewed and the restriction may again be renewed.

(e) A Medicaid ~~recipient~~ **member** affected by the initial restriction under subsection (c) or continued restriction of benefits under subsection (d) may appeal the restrictions. ~~Recipient~~ **Member** appeal rights shall be those provided for in 42 CFR as required by IC 12-15-28-1, and the notice and hearing will be in accordance with the requirements of 42 CFR 431.200 et seq. and 405 IAC 1.1-1-3.

(f) Before providing any Medicaid covered service, each ~~Medicaid~~ provider shall check the Medicaid card of the individual for whom the provider is performing the service. Failure to do so would result in denial of the provider's claim if the individual is not eligible or the service is not authorized. In checking the Medicaid card, the provider must determine all of the following:

(1) The Medicaid card is valid for the month in which the service is being provided.

(2) The individual whose name appears on the Medicaid card is the same individual for whom the service is being performed.

(3) No restriction or restrictions appearing on the Medicaid card would prohibit the provider from performing the requested service.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-102; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 249; filed Oct 7, 1982, 3:50 p.m.: 5 IR 2344; filed May 22, 1987, 12:45 p.m.: 10 IR 2280, eff Jul 1, 1987; filed Aug 22, 1994, 10:00 a.m.: 18 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 4, 2011, 3:59 p.m.: 20111130-IR-405110318FRA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-2) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

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

405 IAC 1-1-3 Filing of claims; filing date; waiver of limit; claim auditing; payment liability; third party payments

Authority: 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. 3. (a) ~~Filing of Claims for Reimbursement~~ All provider claims for payment for services rendered to ~~recipients~~ **members** must be originally filed with the ~~Medicaid contractor~~ **office** within twelve (12) months of the

date of the provision of the service. A ~~Medicaid~~ provider who is dissatisfied with the amount of ~~his~~ reimbursement may appeal under the provisions of 470 IAC 1-4. However, prior to filing such an appeal, the provider must either:

(1) resubmit the claim if the reason for denial of payment was due to incorrect or inaccurate billing by the provider;

(2) submit, if appropriate, an adjustment request to the ~~Medicaid Contractor's Adjustment and Resolution Unit;~~ **office;** or

(3) submit a written request to the ~~Medicaid contractor,~~ **office,** stating why the provider disagrees with the denial or amount of reimbursement.

(b) All requests for payment adjustments ~~and/or~~ **or** reconsideration, **or both,** of a claim that has been denied must be submitted to the ~~Medicaid contractor~~ **office** within sixty (60) days of the date of notification that the claim was paid or denied. In order to be considered for payment, each subsequent claim resubmission or adjustment request must be submitted within sixty (60) days of the most recent notification that the claim was paid or denied. The date of notification shall be considered to be three (3) days following the date of mailing from the ~~Medicaid contractor.~~ **office.** All claims filed after twelve (12) months of the date of the provision of the service, as well as claims filed after sixty (60) days of the date of notification that the claim was paid or denied shall be rejected for payment unless a waiver has been granted. In extenuating circumstances a waiver of the filing limit may be authorized by the ~~contractor or SDPW~~ **office** when justification is provided to substantiate why the claim could not be filed or refiled within the filing limit. Some examples of situations considered to be extenuating circumstances are:

(1) ~~contractor, state or county~~ **office** error or action that has delayed payment;

(2) reasonable and continuous attempts on the part of the provider to resolve a claim problem;

(3) reasonable and continuous attempts on the part of the provider to first bill and collect from a third party liability source before billing Medicaid; or

(4) failure of Medicare/Medicaid claims to cross over.

(c) The fact that the provider was unaware the ~~recipient~~ **member** was eligible for assistance at the time services were rendered is an acceptable reason for waiving the filing limitation only if the following conditions are met:

(1) The provider's records document that the ~~recipient~~ **member** refused or was physically unable to provide ~~his~~ **the member's** Medicaid number.

(2) The provider can substantiate that ~~he~~ **the provider** continually pursued reimbursement from the patient until such time Medicaid eligibility was discovered.

(3) The provider billed ~~the~~ Medicaid, ~~program,~~ or otherwise contacted Medicaid in writing regarding the situation within sixty (60) days of the date Medicaid eligibility was discovered.

In situations in which a patient receives a Medicaid covered service and then subsequently is determined to be eligible, retroactive to the date of service or before, a waiver of the filing limit, where necessary, may be granted if the provider bills Medicaid within one (1) year of the date of the retroactive eligibility determination. In situations where a ~~recipient~~ **member** receives a service outside Indiana by a provider who has not yet been enrolled or has not received a provider manual at the time services were rendered, the claims filing limitation may be waived, subject to approval by the ~~SDPW.~~ **office.** Such situations will be reviewed on an individual basis by the ~~SDPW~~ **office** to ascertain if the provider made a good faith effort to enroll and submit claims in a timely manner.

(d) ~~Claim Auditing~~ All claims filed for reimbursement shall be reviewed prior to payment by the ~~department or its fiscal contractor,~~ **office** for completeness, including required documentation, appropriateness of services and charges, application of third party obligations, statement of prior authorization when required, and other areas of accuracy and appropriateness as indicated.

(e) ~~Payment Liability~~ Medicaid is only liable for the payment of claims filed by providers who were ~~certified~~ **enrolled** providers at the time the service was rendered and for services provided to persons who were enrolled in ~~the~~ Medicaid ~~program~~ as eligible ~~recipients~~ **members** at the time service was provided. Payment may be made for services rendered during any one (1) or all of the three (3) months preceding the month of Medicaid application if the patient is found to be eligible during such period. ~~As a correlation to this, non-certified~~ **Non-enrolled** providers giving the retroactive service must file a provider application retroactive to the beginning date of eligible service and meet provider ~~certification~~ **enrollment** requirements during the retroactive period. A claim for services which requires prior authorization by the ~~department~~ **office** provided during the retroactive period will not be paid unless such services have been reviewed and approved by the ~~department~~ **office** prior to payment. The claim will not be paid if the services provided are outside the service parameters as established by the ~~department.~~ **office.**

(f) Third party payment **is as follows:**
(1) Resources from health insurance plans available to the ~~recipient~~ **member** shall apply first to defraying the cost of medical services before any share of the Medicaid claim for payment is approved. Such resources shall include, but not be limited to, Medicare, Civilian Health and Medical Plan for Uniform Services (CHAMPUS), other health insurances, and ~~Workman's~~ **Worker's** Compensation. A provider of services to a ~~recipient~~ **member** shall not submit a claim for reimbursement by Medicaid until ~~he~~ **the provider** has first ascertained whether any such resource may be liable for all or part of the cost of the services and has sought reimbursement from that resource. With approval of the ~~state department,~~ **office,** a Medicaid claim may be paid prior to third party payment when the liability of the third party is yet to be determined through court proceedings, such as in paternity cases, or when the third party payment will not be available for an extended period of time, with recoupment by the ~~department~~ **office** required when such third party resources become available.
(2) Third party payments applied to the ~~recipient's~~ **member's** cost of care shall be deducted from the total payment allowable from Medicaid, with Medicaid paying only the balance. Reimbursement rates are determined by the ~~state department~~ **office** according to the requirements of federal and state laws governing rate setting for Medicaid services and shall be accepted as party payor.

(g) No Medicaid reimbursement shall be available for services provided to individuals who are not eligible Medicaid ~~recipients~~ **members** on the date the service is provided.

(h) No Medicaid reimbursement shall be available for services provided outside the parameters of a restricted Medicaid card (see ~~470 IAC 5-1-2~~). **section 2 of this rule).**

(i) A Medicaid provider shall not collect from a Medicaid ~~recipient~~ **member** or from the family of the Medicaid ~~recipient~~ **member** any portion of ~~his~~ **the** charge for a Medicaid covered service which is not reimbursed by ~~the Indiana~~ Medicaid ~~program,~~ except for copayment and any patient liability payment as authorized by law. (See 42 CFR 447.15.)

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-103; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 250; filed Oct 7, 1982, 3:54 p.m.: 5 IR 2345; filed Mar 14, 1986, 4:35 p.m.: 9 IR 1857; filed Mar 15, 1988, 1:59 p.m.: 11 IR 2850; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-3) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.

SECTION 4. 405 IAC 1-1-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1-13 Subrogation of claims

Authority: 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. 13. ~~Subrogation.~~ The ~~Indiana State Department of Public Welfare~~ **office** shall be subrogated to all claims by Medicaid ~~recipients~~ **members** against third parties to the extent of Medicaid benefits received by the ~~recipients,~~ **members,** when the direct or proximate cause of the necessity to pay such benefits is the negligence or other legal liability of such third parties.
~~IC 12-1-7-16~~

(Office of the Secretary of Family and Social Services; 5-198; filed Mar 28, 1978, 8:55 a.m.: Rules and Regs. 1979, p. 320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-11) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-13) by P.L.9-1991, SECTION 131, effective January 1, 1992.

SECTION 5. 405 IAC 1-1-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1-14 Severability; governing provisions; effect of provision inconsistent or invalid with federal

law

Authority: 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. 14. ~~Severability.~~ If any provision in ~~Indiana State Department of Public Welfare Regulations 5-101 et seq.~~ **this title** is or shall become inconsistent with any subsequently enacted amendment to the federal Social Security Act or any regulation promulgated thereunder, the amendment to the Social Security Act or the regulation promulgated thereunder shall govern until such time as ~~the Indiana State Department of Public Welfare Regulations~~ **this title** can be amended. If any part of ~~Indiana State Department of Public Welfare Regulations 5-101 et seq.~~ **this title** or the application of ~~them~~ **it** to any person, entity, or circumstance is held invalid, the invalidity does not affect other provisions or applications of ~~the Regulations~~ **this title** which can be given effect without the invalid provision or application, and to this end ~~Indiana State Department of Public Welfare Regulations 5-101 et seq.~~ **the parts of this title** are severable.

~~IC 12-1-2-2(c)~~
~~IC 12-1-2-3(f)~~
~~IC 12-1-7-15~~

(Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-199; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 255; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-12) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-14) by P.L.9-1991, SECTION 131, effective January 1, 1992.

SECTION 6. 405 IAC 1-1-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1-15 Third party liability; definitions

Authority: 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. 15. (a) The following definitions are intended to apply only to ~~470 IAC 5-1-13:~~ **this section:**

(1) "Final settlement" means payment of money from a third party liable for the injury, illness, or disease of a ~~Medicaid recipient~~ **member** whether by compromise, judgment, court order, or restitution, which payment is intended as the total compensation for the injury, illness, or disease caused by the liable third party.

(2) "Notice" means a written statement of the ~~department's~~ **office's** claim bearing:

(A) a certification that the person named in the notice is a ~~recipient~~ **member** of ~~medical assistance;~~ **Medicaid;** and

(B) the signature of an authorized Medicaid employee.

(3) "Certification" means a statement authenticated by the seal of the ~~state department of public welfare.~~ **office.**

(4) ~~"Department's~~ **"Office's** claim" means a statement of ~~medical assistance~~ **Medicaid** payments made by the ~~department~~ **office** for any Medicaid ~~recipient~~ **member** which has been certified by an authorized Medicaid employee.

(5) "Coordination of benefits" means all activities by which an insurer notifies or is notified by other insurers ~~and/or the~~ **or** Medicaid, ~~Program~~ **or both,** that a claim has been received, for the purpose of establishing primary liability, and/or if previous payment has been made on all or part of the claim.

(b) The ~~department~~ **office** has a lien upon any money or fund payable by any third party who is or may be liable for the medical expenses of a Medicaid ~~recipient~~ **member** when the ~~department~~ **office** provides ~~medical assistance.~~ **Medicaid.** Circumstances under which the ~~department~~ **office** may assert its lien include, but are not limited to, cases where Medicaid has made payment because:

(1) payment from a third party was not immediately available;
(2) there are disputes and delays in the coordination of benefits;
(3) the third party was not identified;
(4) the ~~department~~ **office** erroneously made payment before the third party or all other parties had made payment;
(5) a court order has been issued; or
(6) the ~~recipient~~ **member** asserts a claim against a third party who is or may be liable for the injury, illness, or disease of a Medicaid applicant or ~~recipient.~~ **member.**

(c) The ~~department,~~ **office,** acting in behalf of the Medicaid ~~recipient,~~ **member,** may initiate an action against a third party that is or may be liable for the injury, illness, or disease of a Medicaid ~~recipient~~ **member** because:

(1) the ~~recipient~~ **member** has not done so; and

(2) the time remaining under the statute of limitations for the action is six **(6)** months or less.

(d) In perfecting its lien, the ~~department~~ **office** shall take the following action before the third party makes final settlement to the Medicaid ~~recipient~~ **member** as total compensation for the ~~recipient's~~ **member's** injury, illness, or disease:

(1) serve notice:

(A) to third parties in the manner described in ~~paragraph~~ **subsection** (e); ~~below;~~ and/or

(B) to insurers in the manner described in either **subsection** (e)(3)(C) ~~of this section~~ or ~~subsection~~ (f) as deemed appropriate by the ~~department;~~ **office;** and

(2) file a claim which:

(A) shows the amount of payment made at the time notice is served;

(B) is updated at not less than yearly intervals and shows the total of all identified expenditures and/or average daily cost of the individual's care;

(C) is prepared by the ~~department's staff or the fiscal contractor's~~ **office's** staff; or

(D) is a hard copy of computer generated claims payment records; and

(E) is certified by an authorized Medicaid employee.

(e) The ~~department~~ **office** may perfect its lien by serving notice to third parties in the following manner:

(1) Filing a written notice in the Marion County Circuit Court stating **the following:**

(A) The name and address of the ~~recipient;~~ **member.**

(B) That the individual is eligible for ~~medical assistance;~~ **Medicaid.**

(C) The name of the person or third party alleged to be liable to the injured, ill, or diseased ~~recipient.~~ **member.**

(2) Sending a copy of the notice filed in the Marion County Circuit Court by certified mail to the third party.

(3) Sending a copy of the notice to the following persons or entities if the appropriate names and addresses are determined:

(A) The ~~recipient;~~ **member.**

(B) The ~~recipient's~~ **member's** attorney. ~~and~~

(C) The insurer or other third parties.

(f) The ~~department~~ **office** may serve notice to insurers and/or initiate the coordination of benefits by mailing a notice to the insurer ~~which is:~~ **that:**

(1) **is** on state letterhead; ~~and~~

(2) **is** sent by certified mail; **and**

(3) ~~which~~ includes, if reasonably available to the ~~department,~~ **office,** the following information pertaining to the Medicaid ~~recipient:~~ **member:**

(A) name of employer;

(B) name of policyholder;

(C) employee identification number; and

(D) claim certificate number.

(g) When an insurer has received the notice specified in **subsection** (e)(3)(C) ~~of this section~~ or ~~subsection~~ (f) ~~above~~ prior to making payment on a claim, and the insurer is liable for part or all of a Medicaid ~~recipient's~~ **member's** medical expenses, the insurer shall coordinate the benefits with the ~~department~~ **office** and:

(1) pay the provider of service for bills submitted by the provider unless the ~~department~~ **office** certifies that it has already paid the bill;

(2) reimburse the ~~department~~ **office** for claims submitted by the ~~department;~~ **office;** or

(3) reimburse the ~~department~~ **office** if the provider and the ~~department~~ **office** submit claims for the same services.

(h) An insurer that is put on notice of a claim by the ~~department~~ **office** under either subsection (g)(1), ~~(2)~~ **(g)(2),** or ~~(3)~~ **(g)(3)** and proceeds to pay the claim to a person or entity other than the ~~department~~ **office** is not discharged from payment of the ~~department's~~ **office's** claim.

(i) Once ~~the~~ Medicaid ~~program~~ has been reimbursed for the ~~department's~~ **office's** claim by the insurer, the

insurer has discharged its responsibility for that claim. Neither the insurer nor the ~~recipient~~ **member** shall be held liable for any remaining balance. For any provider seeking adjustments in payment, recourse is limited to an administrative appeal as provided by 470 IAC 1-4.

(j) The rules set forth in subsection (g) ~~above~~ shall also apply when the ~~recipient~~ **member** notifies the insurer that ~~he~~ **the member** has received ~~medical assistance~~ **Medicaid** from the ~~department.~~ **office.** In this case, the insurer is required to initiate coordination of benefits with the ~~department.~~ **office.**

(k) Any clause in any insurance contract which excludes payment when the contract beneficiary is eligible for ~~medical assistance~~ **Medicaid** is void and the insurer shall make payments described in subsection (g). ~~above.~~

(l) The ~~department~~ **office** may waive its lien, at its discretion.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1-15; filed Sep 29, 1982, 3:09 p.m.: 5 IR 2322; filed May 22, 1987, 12:45 p.m.: 10 IR 2282, eff Jul 1, 1987; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-13) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-15) by P.L.9-1991, SECTION 131, effective January 1, 1992.

SECTION 7. 405 IAC 1-1-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1-16 Insurance information; release

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-29

Sec. 16. (a) "Insurer" means any insurance company, prepaid health care delivery plan, self funded employee benefit plan, pension fund, retirement system, group coverage plan, blanket coverage plan, franchise insurance coverage plan, individual coverage plan, family-type insurance coverage plan, Blue Cross/Blue Shield plan, group practice plan, individual practice plan, labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, governmental program plans, fraternal benefits societies, Indiana Comprehensive Health Insurance Association plans, any plan or coverage required or provided by any statute, or similar entity that:

(1) is doing business in this state; and

(2) is under an obligation to make payments for medical services as a result of an injury, illness, or disease suffered by a Medicaid ~~recipient.~~ **member.**

(b) In accordance with ~~IC 12-1-7-24.1,~~ **IC 12-15-29-1,** a Medicaid applicant or ~~recipient~~ **member** or one legally authorized to seek Medicaid benefits on behalf of the applicant or ~~recipient~~ **member** shall be considered to have authorized all insurers to release to the ~~department~~ **office** all available information needed by the ~~department~~ **office** to secure or enforce its rights pertaining to third party liability collection.

(c) Every insurer shall provide to the ~~department,~~ **office,** upon written request, information pertaining to coverage ~~and/or~~ **or** benefits, **or both,** paid or available to an individual under an individual, group, or blanket policy or certificate of coverage when the ~~department~~ **office** certifies that such individual is an applicant for or a ~~recipient~~ **member** of ~~medical assistance.~~ **Medicaid.** Information, to the extent available, regarding the insured may include, but need not be limited to:

(1) name, address, and Social Security number of the insured;

(2) policy numbers, the terms of the policy, and the benefit code;

(3) names of covered dependents whom the state certifies are applicants or ~~recipients;~~ **members;**

(4) name and address of employer, other person, or organization which holds the group policy;

(5) name and address of employer, other person, or organization through which the coverage was obtained;

(6) benefits remaining available under the policy including, but not limited to, coverage periods, life time days, life time funds;

(7) the deductible, and the amount of deductible outstanding for each benefit at the time of the request;

(8) any additional coinsurance information which may be on file;

(9) copies of claims when requested for legal proceedings;

(10) copies of checks and their endorsements when these documents are needed as part of an investigation of a ~~recipient and/or~~ **member or** provider, ~~and~~ **or both;**
(11) other policy information which the ~~department~~ **office** certifies in writing is necessary to secure and enforce its rights pertaining to third party liability collection;
(12) carrier information, including:
(A) name and address of carrier;
(B) adjustor's name and address; and
(C) policy number ~~and/or~~ **or** claim number, **or both; and**
(13) claims information, including:
(A) identity of the individual to whom the service was rendered;
(B) identity of the provider rendering services;
(C) identity and position of provider's employee rendering said services, if necessary for claims processing;
(D) date on which said services were rendered; and
(E) a detailed explanation of charges and benefits.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1-16; filed Sep 29, 1982, 3:21 p.m.: 5 IR 2320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-14) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-16) by P.L.9-1991, SECTION 131, effective January 1, 1992.

SECTION 8. 405 IAC 1-1.6-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1.6-1 Scope

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 1. (a) This rule applies to disputes relating to claims submitted to risk-based managed care organizations (MCOs) contracted with the office ~~of Medicaid policy and planning (office)~~ by providers who are not contracted with the MCO and who provide services to a Medicaid ~~recipient~~ **member** enrolled in a risk-based managed care plan.

(b) This rule governs the procedures for a provider's objection to a determination by the MCO involving the provider's claim, including a provider's objection to:
(1) any determination by the MCO regarding payment for a claim submitted by the provider, including the amount of such payment; or
(2) the MCO's determination that a claim submitted by the provider lacks sufficient supporting information, records, or other materials.

(c) The procedures in this rule may, at the election of a provider, be utilized to determine the payment due for a claim in the event the MCO fails, within thirty (30) days after the provider submits the claim, to notify the provider of its determination:
(1) regarding payment for the provider's claim; or
(2) that the provider's claim lacked sufficient supporting information, records, or other materials.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-1; filed Nov 10, 2004, 3:15 p.m.: 28 IR 816; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 9. 405 IAC 1-3-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-3-2 Intermediate level of care criteria

Authority: IC 12-15-1-1; IC 12-15-1-10
Affected: IC 12-15-5-1

Sec. 2. (a) Intermediate nursing care includes care for patients with long term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention. Intermediate care services encompass a range of services from

those below skilled level services to those above room and board level services. The determination of the differences between the skilled and intermediate level of care is based upon the patient's condition, along with the complexity and range of medical services required by the patient on a daily basis. The provision of room, food, laundry, and supervision of activities of daily living do not, in and of themselves, qualify as intermediate care.

(b) Intermediate care includes room, food, laundry, and professional supervision of activities for protection and safety, along with combinations of the following:

(1) Assistance with ambulation.
(2) Assistance with transfers and positioning.
(3) Assistance with general bathing and hygiene.
(4) Assistance with eating.
(5) Assistance with dressing.
(6) Assistance with toileting/incontinence care.

(c) Intermediate services require some professional supervision, but may be performed by properly trained nonprofessional personnel. The following illustrated services are generally of a supportive nature and are less than skilled level services:

(1) Administration of routine oral medications, eye drops, ointment, or any combination of all of these.
(2) Injections which usually can be self-administered, such as the well-regulated diabetic who receives daily insulin injections. The administration of an occasional or PRN (as needed) intramuscular injection would be considered appropriate for intermediate level of care.
(3) General maintenance care of colostomy or ileostomy, including cleaning colostomy, changing colostomy bags, or routine use of equipment.
(4) Routine insertion and maintenance for patency of indwelling catheters.
(5) Changes of dressings in noninfected, postoperative, or chronic conditions.
(6) Prophylactic and palliative skin care, including bathing and application of medical creams or treatment of minor skin conditions.
(7) Administration of oxygen, after initial phases for a stable, chronic condition.
(8) Routine care of plaster cast and brace patients, including hip spica or body casts.
(9) Heat as palliative treatment.
(10) Provision and supervision of restorative measures.
(11) Provision of skilled services or procedures when the resident's overall condition does not require the intensity of professional nursing services necessary for skilled level of care.
(12) Twenty-four (24) hour a day supervision or direct assistance to maintain safety due to confusion or disorientation that is not related to, or a result of, mental illness.

(d) ~~The Indiana~~ Medicaid ~~program~~ does not make reimbursement for services below the intermediate level of care.

(Office of the Secretary of Family and Social Services; Long Term Care Facilities III; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 272; filed Mar 15, 1988, 1:59 p.m.: 11 IR 2854; filed Mar 10, 1993, 5:00 p.m.: 16 IR 1794; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-3-3) to the Office of the Secretary of Family and Social Services (405 IAC 1-3-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

SECTION 10. 405 IAC 1-4.2-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-1 Policy; scope

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-13-2

Sec. 1. (a) This rule provides general information regarding the criteria for providing home health services to Medicaid ~~recipients~~ **members** and sets forth the criteria for reimbursement for services rendered to Medicaid ~~recipients~~ **members** by home health agencies. The information and procedures contained in this rule apply to ~~Medicaid~~ home health providers licensed by the Indiana state department of health and enrolled as Medicaid providers. Continued participation in ~~the~~ Medicaid ~~program~~ and payment for services are contingent upon maintenance of state licensure and compliance with the Medicaid provider agreement.

(b) In accordance with federal law, reimbursement for home health services will be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available to Medicaid recipients at least to the extent that such care and services are available to the general population in the geographic area.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-1; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3375; filed Oct 8, 1998, 12:23 p.m.: 22 IR 433; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 11. 405 IAC 1-4.2-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-2 Definitions

Authority: IC 12-15-5-11; IC 12-15-21
Affected: IC 12-15-13-2

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

(b) "Center for Medicare & Medicaid Services Home Health Agency Market Basket" means the index of that name published quarterly by Global Insight.

~~(c) "Forms prescribed by the office" means:~~
~~(1) forms provided by the office; or~~
~~(2) substitute forms that have received prior written approval by the office.~~

~~(d)~~ **(c)** "Home health agency" or "HHA" means an agency licensed by ~~the Indiana state department of health~~ **ISDH** to provide home health care and enrolled as a ~~Medicaid~~ provider.

~~(e)~~ **(d)** "Home health care" means health care provided to Medicaid recipients who are medically confined to the home as certified by the attending or primary physician.

~~(f)~~ **(e)** "Hours worked" means the number of total hours paid for home health agency personnel, less the number of hours paid for vacation, holiday, and sick pay.

~~(g) "Office" means the office of Medicaid policy and planning.~~

~~(h)~~ **(f)** "Overhead cost rate" means the flat, statewide rate for all allowable costs not reimbursed through the staffing rate.

~~(i) "Prior authorization" has the meaning set forth in 405 IAC 5-2-20.~~

~~(j)~~ **(g)** "Semivariable cost" means that portion of the overhead cost that is reallocated from the overhead cost to the staffing cost. It consists of the following:
(1) Direct supervision.
(2) Routine medical supplies.
(3) Transportation.
(4) Any other semivariable expenses that must be covered by Medicaid under federal law.

~~(k)~~ **(h)** "Staffing cost rate" means the service-specific wage and benefit rate paid per billable hour and based upon standard personnel-related costs that are a function of staff time spent in the performance of patient care activities.

~~(l)~~ **(i)** "Telehealth services" means the use of telecommunications and information technology to provide

access to health assessment, diagnosis, intervention, consultation, supervision, and information across a distance.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-2; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3375; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1116; filed Oct 8, 1998, 12:23 p.m.: 22 IR 433; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)

SECTION 12. 405 IAC 1-4.2-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-3 Home health care services; general information

Authority: IC 12-15-5-11; IC 12-15-21
Affected: IC 12-15-13-2

Sec. 3. (a) ~~Indiana~~ Medicaid will reimburse HHA providers for the following home health services:
(1) Skilled nursing performed by a registered nurse or licensed practical nurse.
(2) Home health aide services.
(3) Physical and occupational therapies.
(4) Speech pathology services.
(5) Renal dialysis.
(6) Telehealth services.
The services in this subsection must be performed in the home and provided within the limitations set forth in 405 IAC 5-16.

(b) Except as provided in subsection (c), all home health services require prior authorization by submitting a properly completed written request to the office. ~~or its contractor.~~ Prior authorization procedures for home health care are set forth in 405 IAC 5-16-3 and 405 IAC 5-16-3.1.

(c) Prior authorization may be obtained by telephone under the circumstances and subject to the limitations set forth in 405 IAC 5-3-2(b)(3). Services ordered in writing by a physician prior to the patient's discharge from a hospital within the limitations set forth in 405 IAC 5-3-12(2) do not need prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-3; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)

SECTION 13. 405 IAC 1-4.2-3.1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-3.1 Financial report to office; annual schedule; extensions; penalty for untimely filing

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 3.1. (a) Each provider shall submit an annual financial report to the office not later than one hundred fifty (150) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within six (6) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) Extension of the one hundred fifty (150) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10)

days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(c) When an annual financial report is thirty (30) days past due and an extension has not been granted, payment for all ~~Indiana~~ Medicaid claims filed by the provider shall be withheld effective on the first day of the month following the thirtieth ~~(30th)~~ day the annual financial report is past due. Payment shall continue to be withheld until the first day of the month after the delinquent annual financial report is received by the office. After receipt of the delinquent annual financial report, the dollar amount paid to the provider for the claims that were withheld shall be reduced by ten percent (10%). Reimbursement lost because of the ten percent (10%) penalty cannot be recovered by the provider.

(d) When an annual financial report is sixty (60) days past due and an extension has not been granted, the office shall notify the provider that the provider's participation in ~~the Indiana~~ Medicaid ~~program~~ shall be terminated. The termination shall be effective on the first day of the month following the ninetieth ~~(90th)~~ day the annual financial report is past due unless the provider submits the delinquent annual financial report before that date.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-3.1; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 14. 405 IAC 1-4.2-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-4 Home health care services; reimbursement methodology

Authority: IC 12-15
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 4. (a) Home health agencies will be reimbursed for covered services provided to Medicaid ~~recipients~~ **members** through standard, statewide rates, computed as:

(1) one (1) overhead cost rate per provider, per ~~recipient,~~ **member,** per day; plus

(2) the staffing cost rate multiplied by the number of hours spent in the performance of billable patient care activities;

to equal the total reimbursement per visit.

(b) The overhead cost rate is a flat, statewide rate based on ninety-five percent (95%) of the statewide median overhead cost per visit. The statewide median overhead cost per visit is derived in the following manner:

(1) Determine for each HHA total patient-related costs submitted by HHA providers on forms prescribed by the office, less direct staffing and benefit costs, divided by the total number of HHA visits during the Medicaid reporting period for that provider. The result of this calculation is an overhead cost per visit for each HHA.

(2) Array all HHA providers in the state in accordance with their overhead cost per visit, from the highest to the lowest cost.

(3) The statewide median overhead cost per visit is the cost of the agency at the point in the overhead cost array at which one-half (1/2) of the overhead cost observations are from higher-cost agencies and one-half (1/2) are from lower-cost agencies.

(c) The staffing cost rate is a flat, statewide rate based on ninety-five percent (95%) of the statewide median direct staffing and benefit costs per hour for each of the following disciplines:

(1) Registered nurse.
(2) Licensed practical nurse.
(3) Home health aide.
(4) Physical therapist.
(5) Occupational therapist.
(6) Speech pathologist.

(d) The statewide median direct staffing and benefit costs per hour is derived in the following manner:

(1) Determine for each HHA total patient-related direct staffing and benefit costs submitted by HHA providers on forms prescribed by the office, divided by the total number of HHA hours worked during the Medicaid

reporting period for that provider for each discipline. The result of this calculation is a staffing cost rate per hour for each HHA and discipline.

(2) Array all HHA providers in the state in accordance with their staffing cost rate per hour for each discipline, from the highest to the lowest.

(3) The statewide median staffing cost rate per hour for each discipline is the cost of the agency at the point in the staffing cost array in which one-half (1/2) of the cost observations are from agencies with higher staffing rates per hour and one-half (1/2) are from agencies with lower staffing rates per hour.

(e) All HHAs must keep track of and make available for audit total hours paid and hours paid relating to vacation, holiday, and sick pay for all HHA personnel.

(f) Medicare-certified HHA providers are required to submit a Medicaid cost report on forms prescribed by the office and the most recently filed Medicare cost report. Non-Medicare-certified HHA providers are required to submit a Medicaid cost report on forms prescribed by the office and the latest fiscal year end financial statements.

(g) Rate setting shall be prospective, based on the provider's initial or annual cost report for the most recent completed period. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation using the Center for Medicare & Medicaid Services Home Health Agency Market Basket index. The inflation adjustment shall apply from the midpoint of the initial or annual cost report period to the midpoint of the next expected rate period.

(h) The semivariable cost will be removed from the overhead cost calculated in accordance with subsection (b) and added to the staffing cost calculated in accordance with subsection (c), based on hours worked.

(i) Field audits will be conducted yearly on a selected number of home health agencies. Any audit adjustments shall be incorporated into the calculation of agency costs to be included in the rate arrays.

(j) Financial and statistical documentation may be requested by the office. ~~or its contractor.~~ This documentation may include, but is not limited to, the following:

(1) Medicaid cost reports.

(2) Medicare cost reports.

(3) Statistical data.

(4) Financial statements.

(5) Other supporting documents deemed necessary by the office. ~~or the rate setting contractor.~~

Failure to submit requested documentation within thirty (30) days of the date of the request may result in the imposition of the sanctions described in section 3.1(c) and 3.1(d) of this rule and sanctions set forth in IC 12-15-22-1.

(k) Retroactive repayment will be required when any of the following occur:

(1) A field audit identifies overpayment by Medicaid.

(2) The provider knowingly receives overpayment of a Medicaid claim from the office. In this event, the provider must:

(A) complete appropriate Medicaid billing adjustment forms; and

(B) reimburse the office for the amount of the overpayment.

(l) Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, 2017, by three percent (3%) for home health services that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-4; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 332; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 15. 405 IAC 1-4.2-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-6 Telehealth services

Authority: IC 12-15-5-11; IC 12-15-21
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 6. (a) Approved telehealth services are reimbursed separately from other home health agency services. The unit of reimbursement for telehealth services provided by a home health agency is one (1) calendar day.

(b) Reimbursement is available for telehealth services as follows:
(1) One-time amount per client of fourteen dollars and forty-five cents ($14.45) related to an initial face-to-face visit necessary to train the ~~beneficiary~~ **member** to appropriately operate the telehealth equipment.
(2) One (1) payment of nine dollars and eighty-four cents ($9.84) for each day the telehealth equipment is used by a registered nurse (RN) to monitor and manage the client's care in accordance with the written order from a physician.

(c) Rates for telehealth services shall not be adjusted annually.

(d) All equipment and software cost associated with the telehealth services must be separately identified on the provider's annual cost report so that it may be removed from the calculation of overhead costs.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-6; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)

SECTION 16. 405 IAC 1-4.3-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.3-1 Limitations or qualifications to Medicaid reimbursement; litigation expenses

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-14-2

Sec. 1. (a) Notwithstanding ~~405 IAC 1-4, 405 IAC 1-12, and 405 IAC 1-14,~~ **any other sections of this article,** the criteria in this section apply to litigation expenses for nursing facilities, ~~intermediate care facilities for the mentally retarded,~~ **ICFs/IID,** and ~~community residential facilities for the developmentally disabled.~~ **CRFs/DD.**

(b) Legal fees, expenses related to expert witnesses, accounting fees, and other consulting fees shall not be reimbursed by the office as reasonably related medical expenses under ~~the~~ Medicaid ~~program~~ if the expenses are incurred as the result of an administrative or judicial action or proceeding against any agency of the state or the federal government.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.3-1; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2853; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 17. 405 IAC 1-8-2 IS AMENDED TO READ AS FOLLOWS:

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; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 18. 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. Services shall be billed in accordance with provider manuals and update bulletins.

(b) Surgical procedures shall be:
(1) classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology; and
(2) paid a rate established for each ASC payment group.
Outpatient surgeries 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 the Indiana Medicaid statewide allowed amount for that service in effect during state fiscal year 2003.

(c) Payments for emergent care that:
(1) do not include surgery; and
(2) are provided in an emergency department, treatment room, observation room, or clinic;
will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(d) Payments for nonemergent care that:
(1) do not include surgery; and
(2) are provided in an emergency department, treatment room, observation room, or clinic;
will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(e) Reimbursement for laboratory procedures is based on the Medicare fee schedule amounts. Reimbursement for the technical component of radiology procedures shall be based on the ~~Indiana~~ Medicaid physician fee schedule rates for the radiology services technical component.

(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 fee schedule amounts in effect during state fiscal year 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.

(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.

(i) The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b).

(j) Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, 2017, by three percent (3%) for outpatient hospital services (excluding ambulatory surgical center reimbursement) that have been calculated under this rule.

(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; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 16, 2010, 3:35 p.m.: 20100915-IR-405100167FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 19. 405 IAC 1-8-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-8-4 Client copayment

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-6-3; IC 12-15-6-4

Sec. 4. (a) Except for those categories of individuals and services specifically exempted in subsection (e), ~~Indiana~~ Medicaid ~~recipients~~ **members** shall be responsible for paying directly to providers a set portion of the payment for nonemergency services provided in an emergency room setting. Services defined as nonemergency shall be determined by the office.

(b) The amount of copayment to be charged shall be three dollars ($3) for nonemergency services provided in emergency room settings.

(c) The provider shall be responsible for collecting the appropriate copayment amount from the ~~recipient.~~ **member.**

(d) Participating providers may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. This services guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate ~~his or her~~ **the individual's** liability for the copayment.

(e) The following categories of ~~recipients~~ **members** and services are exempt from the copayment requirements:
(1) Services provided to children under eighteen (18) years of age.
(2) Services provided to pregnant women.
(3) Family planning services.
(4) Services provided by a health maintenance organization (HMO) to ~~recipients~~ **members** enrolled in an HMO.
(5) Medicaid ~~recipients~~ **members** residing in participating long term care facilities.

(f) The copayment shall be made by the ~~recipients~~ **members** and collected by the provider. Medicaid reimbursement shall be adjusted to reflect the copayment amount.

(Office of the Secretary of Family and Social Services; 405 IAC 1-8-4; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 20. 405 IAC 1-10.5-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-1 Policy; scope

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 1. Reimbursement for inpatient hospital services, as defined by 42 CFR 440.10, is available to providers enrolled by the office ~~of Medicaid policy and planning (office)~~ as Medicaid providers and who are in good standing. Continued participation in the Medicaid program and payment of inpatient hospital services are contingent upon maintenance of state licensure and conformance with the office's provider agreement. 405 IAC 5-17 and 405 IAC 5-28 establish criteria for providing inpatient hospital services to Medicaid ~~recipients~~ **members** and set forth the types of services for which Medicaid reimbursement may be available.

(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-1; filed Oct 5, 1994, 11:10 a.m.: 18 IR 243; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1082; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 55; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 21. 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 **refined diagnosis-related group** (DRG) grouper" refers to a classification system used to assign inpatient stays to DRGs.

(d) "Base amount" means the rate per Medicaid stay that 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. The term includes, but 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 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 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. 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)~~ **all patient refined (APR)** 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) "Freestanding" does not mean a wing or specialized unit within a general acute care hospital.

~~(m)~~ **(n)** "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.

~~(n)~~ **(o)** "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.

~~(o)~~ **(p)** "Intestinal transplant" means the grafting of either the small or large intestines from a donor into a recipient.

~~(p)~~ **(q)** "Less than one-day stay" means a medical stay of less than twenty-four (24) hours.

~~(q)~~ **(r)** "Level-of-care case" means a medical stay, as defined by the office, that includes psychiatric cases, rehabilitation cases, long term care hospital admissions, and certain burn cases.

~~(r)~~ **(s)** "Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure subject to subsection ~~(q).~~ **(r).**

~~(s)~~ **(t)** "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.~~

~~(t)~~ **(u)** "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.

~~(u)~~ **(v)** "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).~~ **(n).**

~~(v)~~ **(w)** "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.~~

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

~~(x)~~ **(y)** "Multivisceral transplant" means the grafting of either the small or large intestines and one (1) or more of the following organs from a donor into a ~~recipient:~~ **member:**
(1) Liver.
(2) Stomach.
(3) Pancreas.

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

(z) "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.

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

(bb) "Principal diagnosis" means the diagnosis, as described by ~~ICD-9-CM code,~~ **the International Classifications of Diseases, 10th revision,** for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

(cc) "Readmission" means that a patient is admitted into the hospital following a previous hospital admission and discharge for a related condition as defined by the office.

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

(ee) "Relative weight" means a numeric value 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.

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

(gg) "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.

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

(ii) "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; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2482; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 22. 405 IAC 1-10.5-3 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 or, in the case of intestinal or multivisceral transplants, as described under subsection (j). 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 **refined** DRG grouper.

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

(g) Relative weights will be reviewed **periodically** 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) Base amounts will be reviewed ~~annually~~ **periodically** 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 twenty percent (120%) of the statewide base amount for DRG services.

(j) The reimbursement methodology for all covered intestinal and multivisceral transplants shall be equal to ninety percent (90%) of reasonable cost, until such time an appropriate DRG as determined by the office can be assigned. The office will use the most recent cost report data that has been filed and audited by the office ~~or its contractor~~ to determine reasonable costs.

(k) Level-of-care rates will be reviewed ~~annually~~ **periodically** 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.

(l) 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,~~ **740, 750–756, 757 (excluding diagnosis codes for intellectual disabilities-mild, moderate, severe, and profound or not otherwise specified classifiable to F70–F79), 758–760, 841–844, and 860,** as defined and grouped using the all patient **refined** DRG grouper, version ~~14.1.~~ **30.** These DRG numbers represent burn, psychiatric, and rehabilitative care.

(m) 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.

(n) 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.

(o) 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.

(p) Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. Capital per diem rates will be reviewed ~~annually~~ **periodically** 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%).

(q) 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.

(r) 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.

(s) 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. 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.

(t) 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.

(u) 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.

(v) 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 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.

(w) Readmissions for the same or related diagnoses 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.

(x) 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~~ **member'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.

(y) 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 (v). The office may establish a separate outlier threshold or marginal cost factor for such cases.

(z) Special payment policies shall apply to less than twenty-four (24) hour stays. For less than twenty-four (24) hour stays, hospitals will be paid 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; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2484; errata filed Jun 16, 2004, 9:35 a.m.: 27 IR 3580; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 23. 405 IAC 1-10.5-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-4 Reimbursement for new providers and out-of-state providers

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 4. (a) The purpose of this section is to establish payment rates for inpatient hospital facilities that commenced participation in the state Medicaid program after fiscal year 1990 and for out-of-state hospital providers participating in the Indiana Medicaid program.

(b) Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate calculated using the statewide median capital rate, the medical education rate, and, if applicable, the outlier payment calculated using the statewide median cost-to-charge ratio.

(c) Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate calculated using the statewide median capital rate, and the medical education rate.

(d) Outlier payments for inpatient stays reimbursed under subsection (b) shall be determined according to the methodology described in section 3 of this rule. Each out-of-state hospital that submits ~~an Indiana~~ **a** Medicaid hospital cost report will receive a cost-to-charge ratio. All other out-of-state facilities must use the statewide median cost-to-charge ratio to determine applicable cost outlier payments.

(e) To be eligible for a facility-specific per diem medical education rate, out-of-state providers must be located in a city listed in 405 IAC 5-5-2(a)(3) and 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) ~~Indiana~~ Medicaid inpatient days. Providers must submit annually ~~an Indiana~~ **a** Medicaid hospital cost report to be eligible for this reimbursement. The facility-specific per diem medical education rate for an out-of-state provider shall not exceed

the highest in-state medical education per diem rate.

(f) To be considered for a separate base amount for children's hospitals, out-of-state children's hospitals must be located in a city listed in 405 IAC 5-5-2(a)(3) and 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) ~~Indiana~~ Medicaid inpatient days. Providers must submit annually ~~an Indiana~~ **a** Medicaid hospital cost report to be eligible for a separate base amount.

(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-4; filed Oct 5, 1994, 11:10 a.m.: 18 IR 246; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1084; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1517; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA)

SECTION 24. 405 IAC 1-11.5-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-11.5-1 Policy; scope

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-13-2

Sec. 1. (a) Reimbursement for physician services, limited license practitioner services, and nonphysician practitioner services as defined by 42 CFR 440.50 and 42 CFR 440.60(a) is available to providers licensed by the professional licensing agency and 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 services is contingent upon maintenance of state licensure and conformance with the office's provider agreement.

(b) As used in this rule, "physician and limited license practitioner" **or** "LLP" means any of the following:
(1) A doctor of medicine.
(2) A doctor of osteopathy.
(3) A physician group practice.
(4) A primary care group practice.
(5) An optometrist.
(6) A podiatrist.
(7) A dentist who is an oral surgeon.
(8) A chiropractor.
(9) A health service provider in psychology.

(c) As used in this rule, "nonphysician practitioner" or "NPP" means any of the following:
(1) A physical therapist.
(2) An occupational therapist.
(3) A respiratory therapist.
(4) An audiologist.
(5) A speech therapist.
(6) A licensed psychologist.
(7) An independent laboratory or radiology provider.
(8) A dentist who is not an oral surgeon.
(9) A social worker certified through the American Academy of Certified Social Workers (ACSW) or who has a master of social work (MSW) degree, a psychologist with a basic certificate, or a licensed psychologist providing outpatient mental health services in a physician-directed outpatient mental health facility.
(10) An advance practice nurse.
(11) A physician's assistant.
(12) A mental health professional listed in 405 IAC 5-21-1(c)(4) and 405 IAC 5-21-1(c)(6).
(13) An inpatient hospital facility as defined in 405 IAC 1-10.5-2.

(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-1; filed Sep 6, 1994, 3:25 p.m.: 18 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Sep 12, 2008, 12:34 p.m.: 20081008-IR-405080186FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 25. 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
(ii) developed specifically for ~~the Indiana~~ Medicaid ~~program,~~ subject to review by the ~~Medicaid director.~~ **office.**
(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 Centers for Medicare and Medicaid Services~~ **CMS** for the Medicare Part B fee schedule for physician services.
(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~~ **CMS** 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 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 not 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 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.
(5) Blood factor products used during an inpatient hospital stay shall be paid based on the state maximum allowable cost (state MAC) rate for the blood factor products. The state MAC rate for blood factor products is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual acquisition cost will be determined using pharmacy invoices and other information that the office determines is necessary. The office will review the state MAC rates for blood factor products on an ongoing basis and adjust the rates as necessary to:
(A) reflect the prevailing market conditions; and
(B) ensure reasonable access by inpatient hospital providers to blood factor products at or below the applicable state MAC rate.
Inpatient hospitals shall submit claims for reimbursement in accordance with the instructions set forth in the provider manual or update bulletins.
(6) 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~~ **CMS** to take effect January 1 of the following calendar year and adjusted as necessary.

(f) Reimbursement for physician-administered drugs shall be one hundred five percent (105%) of the published wholesale acquisition cost (WAC) of the benchmark National Drug Code (NDC). For benchmark NDCs without a published WAC, the reimbursement for physician-administered drugs shall be the Medicare payment amount as published by ~~the Centers for Medicare and Medicaid Services~~ CMS. If no WAC or Medicare payment amount is available, other pricing metrics may be used as determined by the office. This provision shall not apply to parenteral nutrition and blood factor products.

(g) Notwithstanding all other provisions of this rule, for the period beginning upon the later of the effective date of LSA Document #10-793 or June 27, 2011, and continuing through June 30, 2013, reimbursement shall be reduced by five percent (5%) for chiropractic and podiatric services that have been calculated under this rule and for dental services that are billed using current dental terminology (CDT) codes that have been calculated under this rule.

(h) The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b).

(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; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1901; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Sep 12, 2008, 12:34 p.m.: 20081008-IR-405080186FRA; filed Aug 19, 2010, 3:32 p.m.: 20100915-IR-405100250FRA; filed May 9, 2011, 3:59 p.m.: 20110608-IR-405100793FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 26. 405 IAC 1-11.5-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-11.5-3 Additional provisions

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-21.5-3; IC 12-15-13-2

Sec. 3. (a) Physician reimbursement is subject to all other Medicaid rules not otherwise specifically covered by this section. As an example, the provider of service may not develop or bill ~~the~~ Medicaid ~~program~~ for charges that are in excess of the usual and customary charges billed for similar services to non-Medicaid payers.

(b) In the event that the provider is dissatisfied with rates issued in accordance with this section and has exhausted all interim review procedures provided in this article, it may seek an administrative appeal under IC 4-21.5-3.

(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-3; filed Sep 6, 1994, 3:25 p.m.: 18 IR 89; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 27. 405 IAC 1-12-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-1 Policy; scope

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 6-8.1-10-1; IC 12-13-7-3; IC 12-15-13-4

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid ~~recipients~~ **members** by duly certified nonstate-operated ~~intermediate care facilities for the mentally retarded (ICF/MR),~~ **ICFs/IID,** nonstate-operated ~~ICFs/MR licensed as comprehensive rehabilitative management needs facilities (CRMNF),~~ **CRMNFs,** and nonstate-operated ~~community residential facilities for the developmentally disabled (CRF/DD).~~ **CRFs/DD.** Reimbursement for facilities operated by the state is governed by 405 IAC 1-17. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.
(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

(e) Providers must pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-1; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 28. 405 IAC 1-12-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-2 Definitions

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

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

(b) "All-inclusive rate" means a per diem rate that, at a minimum, reimburses for all nursing or resident:
(1) care;
(2) room and board;
(3) supplies; and
(4) ancillary services;
within a single, comprehensive amount.

(c) "Allowable cost determination" means a computation performed by the office ~~or its contractor~~ to determine the per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

(d) "Allowable per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

(e) "Annualized" means restating an amount to an annual value. This computation is performed by multiplying an amount applicable to a period of less or greater than three hundred sixty-five (365) days, by a ratio determined by dividing the number of days in the reporting period by three hundred sixty-five (365) days, except in leap years, in which case the divisor shall be three hundred sixty-six (366) days.

(f) "Annual or historical financial report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule, which shall constitute a comprehensive basis of accounting.

(g) "Average historical cost of property of the median bed" means the allowable resident-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable resident-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 16(a) of this rule.

(h) "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1 and shall be computed on a statewide basis for like levels of care, with the exceptions noted in this subsection, as follows:
(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing.
(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with

specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.
(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental homes multiplied by one hundred fifty-nine percent (159%).
(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences, the average inflated allowable cost of the median patient day for extensive support needs residences for adults shall be the average inflated allowable cost of the median patient day for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

(i) "Change of provider status" means a bona fide sale, lease, or termination of an existing lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties.

~~(j) "Comprehensive rehabilitative management needs facility" or "CRMNF" has the meaning set forth in 460 IAC 9-1-2(5).~~

~~(k)~~ **(j)** "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

~~(l) "CRF/DD" means a community residential facility for the developmentally disabled.~~

~~(m)~~ **(k)** "DDRS" means the Indiana division of disability and rehabilitative services.

~~(n)~~ **(l)** "Debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

~~(o)~~ **(m)** "Desk review" means a review and application of these regulations to a provider submitted financial report including accompanying notes and supplemental information.

~~(p)~~ **(n)** "Equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year-end.

~~(q)~~ **(o)** "Fair rental value allowance" means a methodology for reimbursing extensive support needs residences for adults for the use of allowable facilities and equipment, based on establishing a rental rate, and a rental valuation on a per bed basis of the facilities and equipment.

~~(r)~~ **(p)** "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

~~(s)~~ **(q)** "Forms prescribed by the office" means:
(1) forms provided by the office; or
(2) substitute forms that have received prior written approval by the office.

~~(t)~~ **(r)** "General line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

~~(u)~~ **(s)** "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

~~(v) "ICF/MR" means an intermediate care facility for individuals with intellectual disabilities commonly referred to as "ICF/IID".~~

~~(w)~~ **(t)** "Like levels of care" means care:

(1) within the same level of licensure provided in a CRF/DD;
(2) provided in a nonstate-operated ~~ICF/MR;~~ **ICF/IID;** or
(3) provided in a nonstate-operated ~~ICF/MR~~ **ICF/IID** licensed as a CRMNF.

~~(x)~~ **(u)** "Non-rebasing year" means the year during which nonstate-operated ~~ICFs/MR~~ **ICFs/IID** and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:
October 1, 2011, through September 30, 2012
October 1, 2013, through September 30, 2014
October 1, 2015, through September 30, 2016
October 1, 2017, through September 30, 2018
And every second year thereafter.

~~(y) "Office" means the Indiana office of Medicaid policy and planning.~~

~~(z)~~ **(v)** "Ordinary patient or resident-related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

~~(aa)~~ **(w)** "Patient or ~~resident/recipient~~ **resident/member** care" means those Medicaid program services delivered to a Medicaid enrolled ~~recipient~~ **member** by a ~~certified Medicaid~~ provider.

~~(bb)~~ **(x)** "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

~~(cc)~~ **(y)** "Reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's length transaction, not to exceed the limitations set out in this rule.

~~(dd)~~ **(z)** "Rebasing year" means the year during which nonstate-operated ~~ICFs/MR~~ **ICFs/IID** and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:
October 1, 2012, through September 30, 2013
October 1, 2014, through September 30, 2015
October 1, 2016, through September 30, 2017
October 1, 2018, through September 30, 2019
And every second year thereafter.

~~(ee)~~ **(aa)** "Related party/organization" means that the provider:
(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;
the organization furnishing the service, facilities, or supplies.

~~(ff)~~ **(bb)** "Routine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

~~(gg)~~ **(cc)** "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

~~(hh)~~ **(dd)** "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule, for all providers, except for providers of extensive support needs residences for adults.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-2; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; filed Aug 15, 1997, 8:47 a.m.: 21 IR 76; filed Oct 31, 1997, 8:45 a.m.: 21 IR 949; filed Aug 14, 1998, 4:27 p.m.: 22 IR 63; errata filed Dec 14, 1998, 11:37 a.m.: 22 IR 1526; filed Sep 3, 1999, 4:35 p.m.: 23 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3121; filed Oct 10, 2002, 10:52 a.m.: 26

IR 718; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 29. 405 IAC 1-12-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

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

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. Costs must be reported in the cost report in accordance with the following authorities, in the hierarchical order listed:

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) Costs must be reported in conformance with generally accepted accounting principles.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) When a field audit indicates that the provider's records are inadequate to support data submitted to the office or the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the **reason or** reasons the extension is necessary.

(d) In the event that the deficiencies in documentation are not corrected within the time limit specified in subsection (c), the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the receipt of a complete response.

(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1).

(4) No rate increases will be allowed until the first day of the month following the receipt of the response and requested documentation, or the expiration of the reduction.

(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

(e) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The ~~audit contractor~~ **office** shall document such adjustments in a finalized exception report.

(3) The ~~rate setting contractor~~ **office** shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.

(f) If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the

revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

(g) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient or resident care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of ~~recipient~~ **member** care. The burden of demonstrating that costs are patient or resident related lies with the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-3; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR- 405130241RFA)

SECTION 30. 405 IAC 1-12-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

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

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial ~~certification~~ **enrollment** of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined by this rule. Private pay charges shall be the lowest usual and ~~ordinary~~ **customary** charge.
(8) Certification statement signed by the provider that:
  (A) the data are true, accurate, related to patient or resident care; and
  (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification statement signed by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the

office ~~or its representatives~~ circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office ~~or its representatives~~ prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office ~~or its representatives~~ shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office or its representatives.

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:
(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received, and the effective date of the Medicaid rate calculated utilizing the delinquent annual financial report shall be the first day of the month after the delinquent annual financial report is received by the office. All limitations in effect at the time of the original effective date of the annual rate review shall apply.
(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost as a result of this penalty cannot be recovered by the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-4; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; filed Aug 14, 1998, 4:27 p.m.: 22 IR 64; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 720; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 31. 405 IAC 1-12-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

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

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the ~~certification~~ **enrollment** date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:
(1) the prior provider's then current rate, including any changes due to a field audit, if applicable; or
(2) the fiftieth percentile rates as computed in this subsection.
Initial interim rates shall be effective upon the later of the ~~certification~~ **enrollment** date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and ~~ICF/MR~~ **ICF/IID** providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) Until the identified threshold number of homes is obtained, the fiftieth percentile rates shall be determined as follows:
(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the fiftieth percentile rates for developmental training homes shall be computed on a statewide basis using current rates of all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing.
(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the fiftieth percentile rate for small behavior management residences for children shall be the fiftieth percentile rate for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.
(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the fiftieth percentile rate for small extensive medical needs residences for adults shall be the fiftieth percentile rate for basic developmental homes multiplied by one hundred fifty-nine percent (159%).

(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences for adults, the fiftieth percentile rate for extensive support needs residences for adults shall be the fiftieth percentile rate for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

(c) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of ~~certified~~ **enrolled** operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year-end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of ~~certification~~ **enrollment** falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of ~~certification~~ **enrollment** falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

(d) The provider's historical financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following at a minimum:

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident-related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined in this rule; private pay charges shall be the lowest usual and ~~ordinary~~ **customary** charge.
(8) Certification by the provider that:
  (A) the data are true, accurate, and related to patient or resident care; and
  (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer, by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(e) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(f) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation and an extension has not been granted, the initial interim rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider. The effective date of the base rate calculated utilizing the delinquent historical financial report shall be the first day of the month after the delinquent historical financial report is received by the office. All limitations in effect at the time of the original effective date of the base rate review shall apply.

(g) Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-5; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2317; filed Aug 21, 1996, 2:00 p.m.: 20 IR 12; filed Aug 15, 1997, 8:47 a.m.: 21 IR 78; filed Oct 31, 1997, 8:45 a.m.: 21 IR 950; filed Sep 3, 1999, 4:35 p.m.: 23 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3123; filed Oct 10, 2002, 10:52 a.m.: 26 IR 721; filed Aug 7, 2007, 10:27 a.m.:

20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 32. 405 IAC 1-12-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-7 Request for rate review; effect of inflation; occupancy level assumptions

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

Sec. 7. (a) Rate setting during rebasing years shall be based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs during rebasing years, each provider's costs from the most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for:

(1) mortgage interest on facilities and equipment;
(2) depreciation on facilities and equipment;
(3) rent or lease costs for facilities and equipment; and
(4) working capital interest;

shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For purposes of determining the average allowable cost of the median patient day as applicable during rebasing years, each provider's costs from their most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for:

(1) mortgage interest on facilities and equipment;
(2) depreciation on facilities and equipment;
(3) rent or lease costs for facilities and equipment; and
(4) working capital interest;

shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint prescribed as follows:

Median Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(c) For ~~ICFs/MR~~ **ICFs/IID** and CRFs/DD, allowable costs per patient or resident day shall be determined based on an occupancy level equal to the greater of actual occupancy, or ninety-five percent (95%) for ~~ICFs/MR~~ **ICFs/IID** and ninety percent (90%) for CRFs/DD, for certain fixed facility costs. The fixed costs subject to this minimum occupancy level standard include the following:

(1) Director of nursing wages.
(2) Administrator wages.
(3) All costs reported in the ownership cost center, except repairs and maintenance.
(4) The capital return factor determined in accordance with sections 12 through 17 of this rule for all providers, except for providers of extensive support needs residences for adults.
(5) The fair rental value allowance determined in accordance with section 20.5 of this rule for providers of extensive support needs residences for adults.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-7; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; filed Sep 3, 1999, 4:35 p.m.: 23 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 723; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 33. 405 IAC 1-12-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-9 Criteria limiting rate adjustment granted by office

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

Sec. 9. During rebasing years and for base rate reviews, the Medicaid reimbursement system is based on recognition of the provider's allowable costs plus a potential profit add-on payment. The payment rate established during rebasing years and for base rate reviews is subject to the following limitations:

(1) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services. For purposes of this rule, the rates paid by the general public shall not include rates paid by the DDRS.

(2) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

(3) Inflated allowable per patient or per resident day costs plus the allowed profit add-on payment as determined by the methodology in Table I.

(4) In no instance shall the approved Medicaid rate exceed the overall rate limit percent (Column A) in Table II, times the average inflated allowable cost of the median patient or resident day.

TABLE I
Profit Add-On

The profit add-on is equal to the percent (Column A) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient or resident day cost, and the ceiling (Column B) times the average inflated allowable per patient or resident day cost of the median patient or resident day. Under no circumstances shall a provider's per patient or resident day profit add-on exceed the cap (Column C) times the average inflated allowable per patient or resident day cost of the median patient or resident day.

Level of Care	(A) Percent	(B) Ceiling	(C) Cap
Sheltered living	40%	105%	10%
Intensive training	40%	120%	10%
Child rearing	40%	130%	12%
Nonstate-operated ~~ICF/MR~~ **ICF/IID**	40%	125%	12%
Developmental training	40%	110%	10%
Child rearing with a specialized program	40%	120%	12%
Small behavior management residences for children	40%	120%	12%
Basic developmental	40%	110%	10%
Small extensive medical needs residences for adults	40%	110%	10%
Extensive support needs residences for adults	40%	110%	10%

TABLE II
Overall Rate Limit

Level of Care	(A) Percent
Sheltered living	115%
Intensive training	120%
Child rearing	130%
Developmental training	120%
Child rearing with a specialized program	120%
Small behavior management residences for children	120%
Basic developmental	120%
Small extensive medical needs residences for adults	120%
Extensive support needs residences for adults	120%
Nonstate-operated ~~ICF/MR~~ **ICF/IID**	107%

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-9; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2320; filed Aug 15, 1997, 8:47 a.m.: 21 IR 79; filed Oct 31, 1997, 8:45 a.m.: 21 IR 951; filed Aug 14, 1998, 4:27 p.m.: 22 IR 65; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124; filed Oct 10, 2002, 10:52 a.m.: 26 IR 724; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 34. 405 IAC 1-12-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-15 Allowable costs; capital return factor; use fee; depreciable life; property basis

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

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition, for all providers, except for providers of extensive support needs residences for adults, shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080
10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500
3/1/87	$21,900
9/1/87	$22,400
3/1/88	$22,600
9/1/88	$23,000
3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700

The schedule shall be updated semiannually effective on March 1 and September 1 by the office and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The capital return factor portion of a rate, for all providers, except for providers of extensive support needs residences for adults, that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor, which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on the following:
(A) The maximum property basis per bed at the time of acquisition of each bed, plus one-half (1/2) of the difference between that amount and the maximum property basis per bed at the rate effective date.
(B) The term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983.
(C) The allowable interest rate is the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on the following:
(A) The allowable equity as established under section 14 of this rule.
(B) The rate of return on equity is the greater of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be not greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (1/2) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under ~~the Indiana~~ Medicaid ~~program,~~ shall not be recognized as an allowable cost:
(1) Legal fees.
(2) Accounting and administrative costs.
(3) Travel costs.
(4) The costs of feasibility studies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-15; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2324; filed Sep 1, 2000, 2:10 p.m.: 24 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 726; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 35. 405 IAC 1-12-19 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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

Sec. 19. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided the:
(1) employees are engaged in patient or resident care-related functions; and
(2) compensation amounts are reasonable and allowable under this section and sections 20 through 22 of this rule.

(b) The provider shall report using the forms or in a format prescribed by the office all patient and resident-related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by employees. If a service is performed through a contractual agreement, imputed hours for contracted services are only required when the services obviate the need for staffing of a major function or department that is normally staffed by in-house personnel. For all providers, except for providers of

extensive support needs residences for adults:

(1) hours for laundry services in CRF/DD or ~~ICF/MR~~ **ICF/IID** facilities that are properly documented through appropriate time studies, whether paid in-house or contracted, shall not be included in calculating the staffing limitation for the facility; and

(2) hours associated with the provision of day services and other ancillary services, except as specified in subsection (d), shall be excluded from the staffing limitation.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owners or related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owners or related parties is not subject to the limitation found in section 20 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-19; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 729; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 36. 405 IAC 1-12-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-21 Nonstate-operated intermediate care facilities for individuals with intellectual disabilities; allowable costs; compensation; per diem rate

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

Sec. 21. (a) The procedures described in this section are applicable to ~~intermediate care facilities for the mentally retarded~~ **ICFs/IID** with nine (9) or more beds only, notwithstanding the application of standards and procedures set forth in sections 1 through 20 of this rule.

(b) The per diem rate for ~~intermediate care facilities for the mentally retarded~~ **ICFs/IID** is an all-inclusive rate. The per diem rate includes all services provided to patients by the facility.

(c) Costs related to staffing shall be limited to seven (7) hours worked per patient day.

(d) Any ~~ICFs/MR~~ **ICFs/IID** that is licensed as a CRMNF will be paid at a rate of six hundred twenty-six dollars and twenty-six cents ($626.26) per resident day. This per diem rate is available only upon certification as a Medicaid ~~ICF/MR~~ **ICF/IID** and licensure by the division of disability and rehabilitative services. ~~ICFs/MR~~ **ICFs/IID** that are licensed as CRMNFs are not subject to other rate adjustments identified in this rule except for 405 IAC 1-12-27 and will not receive a base rate nor be subject to the base rate reporting requirements at section 5 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-21; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 37. 405 IAC 1-12-22 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-22 Community residential facilities for the developmentally disabled; allowable costs;

compensation; per diem rate

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

Sec. 22. (a) Notwithstanding the application of standards and procedures set forth in sections 1 through 20.5 of this rule, the procedures described in this section apply to ~~intermediate care facilities for the mentally retarded~~ **ICFs/IID** with eight (8) or fewer beds ~~(community residential facilities for the developmentally disabled),~~ **(CRFs/DD),** except for ~~intermediate care facilities for the mentally retarded~~ **ICFs/IID** licensed as:

(1) small behavior management residences for children for which the procedures described in this section apply to facilities with six (6) or fewer beds;

(2) small extensive medical needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds; and

(3) extensive support needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds.

(b) Costs related to staffing shall be limited to the following:

Type of License	Staff Hours Per Resident Day
Sheltered living	4.5
Intensive training	6.0
Developmental training	8.0
Child rearing	8.0
Child rearing residences with specialized programs	10.0
Basic developmental	10.0
Small behavior management residences for children	12.0
Small extensive medical needs residences for adults	12.0
Extensive support needs residences for adults	24.0

(c) Any change in staffing that exceeds the current limitations of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children will require approval on a case-by-case basis, upon application by the facility. This approval will be determined in the following manner:

(1) A new or current provider of service that seeks staffing above four and one-half (4.5) hours per resident day for adults or eight (8) hours per resident day for children must first obtain approval from the DDRS, based upon the DDRS assessment of the program needs of the residents. The DDRS will establish the maximum number of staff hours per resident day for each facility, which may be less than but may not be more than the ceiling for each type of license. If a change in type of license is required to permit the staffing limitation determined by the DDRS, then the DDRS will make its recommendation to the licensing authority and convey to the office ~~of Medicaid policy and planning~~ the decision of the licensing authority. The office shall:

(A) conduct a complete and independent review of a request for increased staffing; and

(B) retain final authority to determine whether a rate change will be granted as a result of a change in licensure type.

(2) If a provider of services holds a current license that would permit staffing above the limitation of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children, but the provider does not seek approval of staffing beyond those limitations, then the DDRS may investigate whether the provider holds the appropriate type of license.

(d) The per diem rate shall be an all-inclusive rate. The established rate includes all services provided to residents by a facility. The office shall not set a rate for more than one (1) level of care for each ~~community residential facility for the developmentally disabled~~ **CRF/DD** provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-22; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; filed Aug 15, 1997, 8:47 a.m.: 21 IR 81; filed Oct 31, 1997, 8:45 a.m.: 21 IR 953; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 38. 405 IAC 1-12-23 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-23 Medical or nonmedical supplies and equipment; personal care items

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

Sec. 23. (a) Routine and nonroutine medical supplies and equipment are included in the provider's approved per diem rate, and the provider shall not bill ~~the~~ Medicaid ~~program~~ for such items in addition to the established rate. Under no circumstances shall the routine and nonroutine medical supplies and equipment be billed through a pharmacy or other provider. Routine supplies and equipment include those items routinely required for the care of residents. Nonroutine medical supplies and equipment are those items for which the need must be demonstrated by the resident's particular condition and identifiable to that resident. The medical records of each resident must indicate, by specific written physician's orders, the order for the service or supply furnished and the dispensing of the service or supply to the resident.

(b) Personal care or comfort items include the following:
(1) Hairbrushes and combs.
(2) Dental adhesives and caps.
(3) Toothpaste.
(4) Shower caps.
(5) Nail files.
(6) Lemon glycerine swabs.
(7) Mouthwashes.
(8) Toothbrushes.
(9) Deodorants.
(10) Shampoos.
(11) Disposable tissues.
(12) Razor.
(13) Any other items or equipment covered by Medicaid and specifically requested by a resident and not routinely provided by the provider.

These items may be included in the approved room charge. Under no circumstances shall items included as personal care or comfort be billed through a pharmacy or other provider to ~~the~~ Medicaid. ~~program.~~

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-23; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 39. 405 IAC 1-12-24 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-24 Assessment methodology

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-32-11

Sec. 24. (a) CRF/DD and ~~ICF/MR~~ **ICF/IID** facilities that are not operated by the state will be assessed an amount that is based on total annual facility revenue. In determining total annual revenue when the financial report period is other than three hundred sixty-five (365) days, the total revenue shall be annualized based on the number of days in the reporting period. The assessment percentage applied to total annual revenue shall be six percent (6%). In no event shall the assessment percentage exceed the percentage determined to be eligible for federal financial participation under federal law.

(b) The assessment on provider total annual revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Total annual revenue is determined as follows:
(1) For an annual rate review, from the provider's previous annual financial reporting period as set out in section 4(a) of this rule.
(2) For a base rate review, from the provider's previous base financial reporting period as set out in section 5(c) of this rule.
(3) For an initial interim rate review for a new provider that is not the result of a change of ownership, the fiftieth percentile provider's assessment for a like level of care shall be used as determined in section 5(a) of this rule. The fiftieth percentile provider's assessment is divided by their resident days to determine the assessment per resident day amount. The assessment per resident day amount is then multiplied by the

annualized bed days available to determine the new provider's annualized assessment.

Providers will submit data to calculate the amount of provider assessment with their annual and base rate reviews as set out in sections 4(a) and 5(c) of this rule, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(c) If federal financial participation to match the assessment becomes unavailable under federal law after the implementation date, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes place, and such termination will apply prospectively. In addition, prospective termination of the assessment as described in this subsection will result in the simultaneous termination of the assessment being considered as an allowable cost for rate setting purposes.

(d) For an ~~ICFs/MR~~ **ICF/IID** that is licensed as a CRMNF, the total annual revenue on which the assessment is based shall be determined as follows:

(1) For the initial interim rate review, available bed days times the projected occupancy rate of sixty-nine percent (69%) times the approved Medicaid rate issued to the provider.

(2) For annual rate reviews, from the provider's previous annual financial reporting period as set out in section 4(a) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-24; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; filed Aug 14, 1998, 4:27 p.m.: 22 IR 67; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:40 a.m.: 25 IR 381; filed Oct 10, 2002, 10:52 a.m.: 26 IR 730; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jul 31, 2008, 4:12 p.m.: 20080827-IR-405070647FRA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 40. 405 IAC 1-12-25 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-25 Reimbursement for day services

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

Sec. 25. For ~~ICF/MR~~ **ICF/IID** and CRF/DD facilities, the all-inclusive per diem rate shall include reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate setting purposes in accordance with all sections of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-25; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2330; filed Aug 14, 1998, 4:27 p.m.: 22 IR 68; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 41. 405 IAC 1-12-26 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-26 Administrative reconsideration; appeal

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5-3; IC 12-13-7-3

Sec. 26. (a) The ~~Medicaid rate-setting contractor~~ **office** shall notify each provider of the provider's rate and allowable cost determinations after they have been computed. If the provider disagrees with the rate or allowable cost determinations, the provider may request an administrative reconsideration by the ~~Medicaid rate-setting contractor.~~ **office.** Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the ~~contractor~~ **office** not later than forty-five (45) days after release of the rate or allowable cost determinations as computed by the ~~Medicaid rate-setting contractor.~~ **office.** Upon receipt of the request for reconsideration, the ~~Medicaid rate-setting contractor~~ **office** shall evaluate the data. After review, the ~~Medicaid rate-setting contractor~~ **office** may amend the rate, amend the

challenged procedure or allowable cost determination, or affirm the original decision. The ~~Medicaid rate-setting contractor~~ **office** shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the ~~Medicaid rate-setting contractor's~~ **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the ~~rate-setting contractor~~ **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with the preliminary recalculated Medicaid rate or allowable cost redetermination resulting from a financial audit adjustment or reportable condition the provider may request an administrative reconsideration from the ~~Medicaid audit contractor.~~ **office.** Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the ~~Medicaid audit contractor~~ **office** not later than forty-five (45) days after release of the preliminary recalculated Medicaid rate or allowable cost determinations as computed by the ~~Medicaid rate-setting contractor.~~ **office.** Upon receipt of the request for reconsideration, the ~~Medicaid audit contractor~~ **office** shall evaluate the data. After review, the ~~Medicaid audit contractor~~ **office** may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The ~~Medicaid audit contractor~~ **office** shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the ~~Medicaid audit contractor's~~ **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the ~~audit contractor~~ **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal must be signed by the provider.

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-26; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 730; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 42. 405 IAC 1-12-27 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-27 Rate reduction

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

Sec. 27. Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, 2017, by one percent (1%) for services provided by all privately (nonstate) owned ~~intermediate care facilities for the mentally retarded (ICFs/MR)~~ **ICFs/IID** and ~~community residential facilities for the developmentally disabled~~ CRFs/DD that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-27; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 43. 405 IAC 1-13-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-13-1 Eligibility

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-6

Sec. 1. (a) Eligibility for basic and enhanced disproportionate share hospital payments for hospital providers that are not owned or operated by the state will be determined using a provider's Medicaid inpatient utilization rate

and low income utilization rate based on utilization and revenue data from the cost reporting period used to determine that provider's eligibility for disproportionate share payments as of July 1, 1992.

(b) Hospital providers that are owned or operated by the state are eligible for disproportionate share hospital payments for a fiscal year if:

(1) for any portion of that fiscal year, the provider meets ~~the Health Care Financing Administration's~~ **CMS's** conditions of participation for the Medicare program;

(2) for any portion of that fiscal year, the provider is eligible for Medicaid payments;

(3) the hospital's low income utilization rate for that fiscal year exceeds twenty-five percent (25%); and

(4) the hospital's Medicaid utilization rate exceeds one percent (1%).

(Office of the Secretary of Family and Social Services; 405 IAC 1-13-1; filed Jan 27, 1994, 5:00 p.m.: 17 IR 1090; filed May 25, 1995, 3:00 p.m.: 18 IR 2409; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 44. 405 IAC 1-13-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-13-2 Basic disproportionate share payments

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-6

Sec. 2. (a) For purposes of determining the proportional distribution to be made from the disproportionate share pool for basic disproportionate share payments to hospital providers eligible under section 1(a) of this rule, the provider's utilization and revenue data shall be for the same cost reporting period as in section 1(a) of this rule.

(b) Basic disproportionate share distributions from the disproportionate share pool to hospital providers eligible under section 1(b) of this rule shall be based on the hospital's costs during the fiscal year for services furnished to individuals who are either of the following:

(1) Eligible for ~~medical assistance~~ **Medicaid** under the state plan.

(2) Have no health insurance or other source of third party coverage for services provided during the fiscal year and whose personal resources are inadequate to cover the cost of the services furnished. For purposes of this subdivision, payments made to a hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered a source of third party payment.

(Office of the Secretary of Family and Social Services; 405 IAC 1-13-2; filed Jan 27, 1994, 5:00 p.m.: 17 IR 1090; filed May 25, 1995, 3:00 p.m.: 18 IR 2409; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 45. 405 IAC 1-14.6-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-1 Policy; scope

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 6-8.1-10-1; IC 12-13-7-3; IC 12-15-13-4; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid ~~recipients~~ **members** by ~~duly certified~~ nursing facilities. ~~(NF).~~ All payments referred to within this rule are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, access, efficiency, economy, and consistency. These procedures recognize level and quality of care, access, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and, only to the extent the state is required to by state law, compensate providers for reasonable, allowable costs which must be incurred by efficiently and economically operated facilities. The system of payment

outlined in this rule is a prospective system. Cost limitations are contained in this rule that establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive payment or repayment will be required when an audit verifies an underpayment or overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data, or resident assessment data which caused a lower or higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

(e) Providers must pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall:
(1) accrue from the date of the overpayment to the provider; and
(2) apply to the net outstanding overpayment during the periods in which such overpayment exists.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-1; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 46. 405 IAC 1-14.6-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-2 Definitions

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

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

(b) "Administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:
(1) Administrator and co-administrators, owners' compensation (including director's fees) for patient-related services.
(2) Services and supplies of a home office that are:
(A) allowable and patient-related; and
(B) appropriately allocated to the nursing facility.
(3) Office and clerical staff.
(4) Legal and accounting fees.
(5) Advertising.
(6) All staff travel and mileage.
(7) Telephone.
(8) License dues and subscriptions.
(9) All office supplies used for any purpose, including repairs and maintenance charges and service agreements for copiers and other office equipment.
(10) Working capital interest.
(11) State gross receipts taxes.
(12) Utilization review costs.
(13) Liability insurance.
(14) Management and other consultant fees.
(15) Qualified ~~mental retardation~~ **intellectual disability** professional. ~~(QMRP).~~
(16) Educational seminars for administrative staff.
(17) Support and license fees for all general and administrative computer software and hardware such as accounting or other data processing activities.

(c) "Allowable per patient day cost" means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed annual financial report, plus a ratio between allowable fixed costs and patient days using the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

(d) "Allowed profit add-on payment" means the portion of a facility's tentative profit add-on payment that, except as may be limited by application of the overall rate ceiling as defined in this rule, shall be included in the facility's Medicaid rate, and is based on the facility's total quality score.

(e) "Annual financial report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.

(f) "Average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable variable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed desk reviewed annual financial report. The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(g) "Average historical cost of property of the median bed" means the allowable patient-related property cost per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

(h) "Calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(i) "Capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property insurance.

(j) "Case mix index" or "CMI" means a numerical value score that describes the relative resource use for each resident within the groups under the resource utilization group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

(k) "Children's nursing facility" means a nursing facility that, as of January 1, 2009, has:

(1) fifteen percent (15%) or more of its residents who are under the chronological age of twenty-one (21) years; and

(2) received written approval from the office to be designated as a children's nursing facility.

(l) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(m) "Delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the date defined by CMS for determining delinquency or an assessment that is not completed within the time prescribed in the guidelines for use in determining the time-weighted CMI under section 9(e) of this rule. This determination is made on the fifteenth day of the second month following the end of a calendar quarter.

(n) "Desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(o) "Direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all of the following:

(1) Nursing and nursing aide services.
(2) Nurse consulting services.
(3) Pharmacy consultants.
(4) Medical director services.
(5) Nurse aide training.
(6) Medical supplies.
(7) Oxygen.
(8) Medical records costs.
(9) Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators. Rental costs for these items are limited to one dollar and fifty cents ($1.50) per resident day.
(10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.
(11) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures.
(12) Legend and nonlegend sterile water products used for irrigation or humidification.
(13) Educational seminars for direct care staff.
(14) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis by the member, nursing facility care staff, or by prescriber's order as a part of routine care as defined in subsection ~~(gg).~~ **(ff).**

(p) "Fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(q) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(r) "Fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements as contained in this rule. The following percentages shall be multiplied by total allowable costs to determine allowable fixed costs for each rate component:

Rate Component	Fixed Cost Percentage
Direct Care	25%
Indirect Care	37%
Administrative	84%
Capital	100%

(s) "Forms prescribed by the office" means either of the following:
(1) Cost reporting forms provided by the office.
(2) Substitute forms that have received prior written approval by the office.

(t) "General line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(u) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(v) "Incomplete MDS resident assessment" means an assessment that is not printed by the nursing facility provider upon request by the office. ~~or its contractor.~~

(w) "Indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:
(1) Dietary services and supplies.
(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.
(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.
(11) Cable or satellite television throughout the nursing facility, including residents' rooms.
(12) Pets, pet supplies and maintenance, and veterinary expenses.
(13) Educational seminars for indirect care staff.
(14) All costs related to nonambulance travel and transportation of residents.

(x) "Medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients.

(y) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in ~~the~~ Medicaid. ~~program.~~ The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (9/2000) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by ~~the Centers for Medicare and Medicaid Services~~ CMS.

(z) "Normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average CMI for all residents.

(aa) "Nursing home report card score" means a numerical score developed and published by ~~the Indiana state department of health~~ ISDH that quantifies each facility's key survey results.

~~(bb) "Office" means the office of Medicaid policy and planning.~~

~~(cc)~~ **(bb)** "Ordinary patient-related costs" means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

~~(dd) "Patient/recipient~~ **(cc) "Patient/member** care" means those Medicaid program services delivered to a Medicaid enrolled ~~recipient~~ **member** by a ~~certified Medicaid~~ provider.

~~(ee)~~ **(dd)** "Reasonable allowable costs" means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

~~(ff)~~ **(ee)** "Related party/organization" means that the provider:
(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;

the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

~~(gg)~~ **(ff)** "Routine care" means care that does not treat or ameliorate a specific defect or specific physical or mental illness or condition.

~~(hh)~~ **(gg)** "RUG-III resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI for all residents and facility-average CMI for Medicaid residents.

~~(ii)~~ **(hh)** A nursing facility with a "special care unit (SCU) for Alzheimer's disease or dementia" means a nursing facility that meets all of the following:

(1) Has a locked, secure, segregated unit or provides a special program or special unit for residents with Alzheimer's disease, related disorders, or dementia.

(2) The facility advertises, markets, or promotes the health facility as providing Alzheimer's care services or dementia care services, or both.

(3) The nursing facility has a designated director for the Alzheimer's and dementia special care unit, who satisfies all of the following conditions:

(A) Became the director of the SCU prior to August 21, 2004, or has earned a degree from an educational institution in a health care, mental health, or social service profession, or is a licensed health facility administrator.

(B) Has a minimum of one (1) year work experience with dementia or Alzheimer's, or both, residents within the past five (5) years.

(C) Completed a minimum of twelve (12) hours of dementia specific training within three (3) months of initial employment and has continued to obtain six (6) hours annually of dementia-specific training thereafter to:

(i) meet the needs or preferences, or both, of cognitively impaired residents; and

(ii) gain understanding of the current standards of care for residents with dementia.

(D) Performs the following duties:

(i) Oversees the operations of the unit.

(ii) Ensures personnel assigned to the unit receive required in-service training.

(iii) Ensures the care provided to Alzheimer's and dementia care unit residents is consistent with in-service training, current Alzheimer's and dementia care practices, and regulatory standards.

~~(jj)~~ **(ii)** "Tentative profit add-on payment" means the profit add-on payment calculated under this rule before considering a facility's total quality score.

~~(kk)~~ **(jj)** "Therapy component" means the portion of each facility's direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this rule.

~~(ll)~~ **(kk)** "Total quality score" means the sum of the quality points awarded to each nursing facility for all eight (8) quality measures as determined in section 7(n)(1) through 7(n)(8) of this rule.

~~(mm)~~ **(ll)** "Unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

~~(nn)~~ **(mm)** "Unsupported MDS resident assessment" means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system:

(1) are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15; and

(2) result in the assessment being classified into a different RUG-III category.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462; filed Oct 10, 2002, 10:47 a.m.: 26 IR 707; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3869; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2975; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA;

readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 47. 405 IAC 1-14.6-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

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

Sec. 3. (a) The basis of accounting under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. Costs must be reported in the cost report in accordance with the following authorities, in the hierarchal order listed:

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) Costs must be reported in conformance with generally accepted accounting principles.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) When a field audit indicates that the provider's records are inadequate to support data submitted to the office, or when the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason or reasons the extension is necessary.

(d) In the event that the deficiencies in documentation are not corrected within the time limit specified in subsection (c), the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the office's receipt of a complete response.

(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1).

(4) No rate increases will be allowed until the first day of the calendar quarter following the office's receipt of the response and requested documentation, or the expiration of the reduction.

(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

(e) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The ~~audit contractor~~ **office** shall document such adjustments in a finalized exception report.

(3) The ~~rate setting contractor~~ **office** shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.

(f) If a provider has business enterprises or activities other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly

identifiable from the records of the operations reimbursed by Medicaid. If a field audit or desk review establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs.

(g) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report coincidental with the time period for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of ~~recipient~~ **member** care. The burden of demonstrating that costs are patient-related lies with the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-3; filed Aug 12, 1998, 2:27 p.m.: 22 IR 71, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 48. 405 IAC 1-14.6-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

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

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial ~~certification~~ **enrollment** of a provider. This option:

(1) may be exercised only one (1) time by a provider; and

(2) must coincide with the fiscal year end for Medicare cost reporting purposes.

If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office. ~~or its contractor.~~ Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(c) The provider's annual financial report shall be completed in accordance with applicable instructions and submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient-related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ~~ordinary~~ **customary** charge.

(8) Certification by the provider that:

(A) the data are true, accurate, and related to patient care; and

(B) expenses not related to patient care have been clearly identified.

(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(10) A copy of the working trial balance that was used in the preparation of their submitted Medicaid cost report.

(11) A copy of the crosswalk document used to prepare the Medicaid cost report that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report.

(12) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

(d) An extension of the five (5) month filing period shall not be granted.

(e) Failure to submit an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services within the time limit required shall result in the following actions:

(1) No rate review shall be accepted or acted upon by the office until the delinquent reports are received.

(2) When an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services is more than one (1) calendar month past due, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the seventh month following the provider's fiscal year end and shall so remain until the first day of the month after the delinquent annual financial report or Medicare cost report (if required) is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider. If the:

(A) Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary; and

(B) provider fails to submit their Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary;

then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. An extension of the electronic MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the:

(1) new operation is not currently enrolled or submitting MDS assessments under the Medicare program; and

(2) provider can substantiate to the office circumstances that preclude timely electronic transmission.

(g) Residents discharged prior to completing an initial assessment that is not preceded by a Medicare assessment or a regularly scheduled assessment will be classified in one (1) of the following RUG-III classifications:

(1) SSB classification for residents discharged before completing an initial assessment where the reason for discharge was death or a transfer to a hospital.

(2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or a transfer to a hospital.

(3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.

(h) If the office ~~or its contractor~~ determines that a nursing facility has incomplete MDS resident assessments, then, for purposes of determining the facility's CMI, the assessment or assessments shall be assigned the CMI associated with the RUG-III group "BC1 - Unclassifiable".

(i) If the office ~~or its contractor~~ determines that a nursing facility has delinquent MDS resident assessments, then, for purposes of determining the facility's CMI, the assessment or assessments shall be assigned the CMI associated with the RUG-III group "BC2 - Delinquent".

(j) If the office ~~or its contractor~~ determines due to an MDS field audit that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:

(1) The office: ~~or its contractor:~~

(A) shall audit a sample of MDS resident assessments; and

(B) determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the initial sample that are unsupported is greater than twenty percent (20%), the office ~~or its contractor~~ shall expand to a larger sample of residents assessments. If the percent of assessments in the initial sample that are unsupported is equal to or less than twenty percent (20%):

(A) the office ~~or its contractor~~ shall conclude the field portion of the MDS audit; and

(B) no corrective remedy shall be applied.

(3) For nursing facilities with MDS audits performed on the initial and expanded sample of residents assessments, the office ~~or its contractor~~ will determine the percent of all assessments audited that are unsupported.

(4) If the percent of assessments for the initial and expanded sample of all assessment audited residents that are unsupported is greater than twenty percent (20%), a corrective remedy shall apply, which shall be calculated as follows:

(A) The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in the following table:

MDS Field Audit for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS field audit	15%
Second consecutive MDS field audit	20%
Third consecutive MDS field audit	30%
Fourth or more consecutive MDS field audit or audits	50%

(B) In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office ~~or its contractor~~ to the provider's allowable administrative costs.

(C) Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments for the initial and expanded sample of all assessments audited that are unsupported is equal to or less than twenty percent (20%):

(A) the office ~~or its contractor~~ shall conclude the MDS audit; and

(B) no corrective remedy shall apply.

(k) Based on findings from the MDS audit the office ~~or its contractor~~ shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office. ~~or its contractor.~~

(l) Upon conclusion of an MDS audit, the office ~~or its contractor~~ shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate:

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

(m) The Employee Turnover report (Schedule X) and the Special Care Unit report (Schedule Z) shall be completed by all providers based on the calendar year (January 1 through December 31) reporting period. Schedules X and Z must be submitted to the office not later than March 31 following the end of each calendar year. Reports submitted after March 31 will not be considered in the determination of the subsequent annual rate review.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-4; filed Aug 12, 1998, 2:27 p.m.: 22 IR 72,

eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2240; errata filed Jun 21, 1999, 12:25 p.m.: 22 IR 3419; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; filed Oct 10, 2002, 10:47 a.m.: 26 IR 709; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 49. 405 IAC 1-14.6-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-5 New provider; initial financial report to office; criteria for establishing initial interim rates

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

Sec. 5. (a) Rate requests to establish an initial interim rate for a new operation shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the ~~certification~~ **enrollment** date. Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, therapy, indirect care, administrative, and eighty percent (80%) of the capital component. Before the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted retroactively to reflect changes, occurring in the first and second calendar quarters of operation, in the provider's CMI for Medicaid residents and adjusted prospectively after the second calendar quarter to reflect changes in the provider's CMI for Medicaid residents. Initial interim rates shall be effective on the:

(1) ~~certification~~ **enrollment** date; or

(2) date that a service is established;

whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this rule shall apply.

(b) Before the first annual rate review, the rate will be adjusted effective on each calendar quarter under section 6(d) of this rule to account for changes in the provider's CMI for Medicaid residents. A provider will not receive a change in the medians for calculating its reimbursement rate until its first annual rate review, which shall coincide with the provider's first fiscal year end that occurs after the initial interim rate effective date in which the provider has a minimum of six (6) months of actual historical data.

(c) In conjunction with establishing an initial interim rate, a new operation shall submit a Nursing Facility Quality Assessment Form that contains projected patient census data from the first day of operation through the provider's first fiscal year end with a minimum of six (6) months of actual historical data. Following completion of the provider's first fiscal year end with a minimum of six (6) months of actual historical data, the provider shall submit a Nursing Facility Quality Assessment Form reporting actual patient census data covering the period from the first day of operation until the provider's first fiscal year end with a minimum of six (6) months of actual historical data. This form shall be submitted to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. Failure to submit a Nursing Facility Quality Assessment Form shall result in the actions specified at section 4(e) of this rule. This form will not be required after the quality assessment expires.

(d) In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, the new provider shall submit a completed Checklist of Management Representations Concerning Change in Ownership to the office ~~or its contractor~~ within thirty (30) days following the date the Checklist of Management Representations request is sent to the provider. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office. ~~or its contractor.~~ If the completed Checklist of Management Representations has not been submitted within ninety (90) days following the date the Checklist of Management Representations request is sent to the provider, the Medicaid rate currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the end of the ninety (90) day period. The penalty shall remain until the first day of the month after the completed Checklist of Management Representations is received by the office. ~~or its contractor.~~ Reimbursement lost because of the penalty cannot be recovered by the provider.

(e) For a new operation, the interim quality assessment and Medicaid rate add-on shall be based on projected

patient days. A retroactive settlement of the quality assessment and Medicaid rate add-on will be determined, based on actual patient days, for the time period from the first day of operation until the first annual rate effective date associated with the provider's first fiscal year end with a minimum of six (6) months of actual historical data.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-5; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2242; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2467; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2978; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 50. 405 IAC 1-14.6-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-6 Active providers; rate review

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

Sec. 6. (a) The:
(1) normalized average allowable cost of the median patient day for the direct care component; and
(2) average allowable cost of the median patient day for the indirect, administrative, and capital components;
shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.

(b) The:
(1) normalized allowable per patient day cost for the direct care component; and
(2) allowable per patient day costs for the therapy, indirect care, administrative, and capital components;
shall be established once per year for each provider based on the annual financial report.

(c) Beginning October 1, 2007, the rate effective date of the annual rate review shall be the first October 1 that falls after the first calendar quarter following the provider's reporting year-end. Beginning July 1, 2008, the rate effective date of the annual rate review shall be the first July 1 that falls after the first calendar quarter following the provider's reporting year-end. The rate effective date of the annual rate review for all providers shall be July 1 of each year thereafter.

(d) Subsequent to the annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual
rate review.

(e) The case mix index for Medicaid residents in each facility shall be:
(1) updated each calendar quarter; and
(2) used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(f) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).

(g) When the number of nursing facility beds licensed by ~~the Indiana state department of health~~ **ISDH** is changed after the annual reporting period, the provider may request in writing before the effective date of their next annual rate review an additional rate review effective on the first day of the calendar quarter on or following the date of the change in licensed beds. This additional rate review shall be determined using all rate-setting parameters in effect at the provider's latest annual rate review, except that the number of beds and associated bed days available for the calculation of the rate-setting limitations shall be based on the newly licensed beds.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-6; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73,

eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3872; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Oct 4, 2007, 2:05 p.m.: 20071031-IR-405070150FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 51. 405 IAC 1-14.6-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices

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

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning July 1, 2017, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, the previous provider's most recently completed annual financial report used to establish a Medicaid rate for the previous provider shall be utilized to calculate the new provider's first annual rate review. The inflation adjustment for the new provider's first annual rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) Allowable fixed costs per patient day for direct care, indirect care, and administrative costs shall be computed based on the following minimum occupancy levels:

(1) For nursing facilities with less than fifty-one (51) beds, an occupancy rate equal to the greater of eighty-five percent (85%), or the provider's actual occupancy rate from the most recently completed historical period.

(2) For nursing facilities with greater than fifty (50) beds, an occupancy rate equal to the greater of ninety percent (90%) or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office ~~or its contractor~~ shall reestablish a provider's Medicaid rate effective on the first day of the quarter following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the applicable minimum occupancy requirement described in subsection (d), if both of the following conditions can be established to the satisfaction of the office:

(1) The provider demonstrates that its current resident census has:

(A) increased to the applicable minimum occupancy level described in subsection (d), or greater since the facility's fiscal year end of the most recently completed and desk reviewed cost report utilizing total nursing facility licensed beds as of the most recently completed and desk reviewed cost report period; and

(B) remained at such level for not fewer than ninety (90) days.

(2) The provider demonstrates that its resident census has:

(A) increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the most recently completed and desk reviewed cost report; and

(B) remained at such level for not fewer than ninety (90) days.

(f) Allowable fixed costs per patient day for capital-related costs shall be computed based on an occupancy rate equal to the greater of ninety-five percent (95%) or the provider's actual occupancy rate from the most recently completed historical period.

(g) Except as provided for in subsection (h), the CMIs contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

RUG-III Group	RUG-III Code	CMI Table
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85
Special Care	SSC	1.75
Special Care	SSB	1.60
Special Care	SSA	1.51
Clinically Complex	CC2	1.33
Clinically Complex	CC1	1.27
Clinically Complex	CB2	1.14
Clinically Complex	CB1	1.07
Clinically Complex	CA2	0.95
Clinically Complex	CA1	0.87
Impaired Cognition	IB2	0.93
Impaired Cognition	IB1	0.82
Impaired Cognition	IA2	0.68
Impaired Cognition	IA1	0.62
Behavior Problems	BB2	0.89
Behavior Problems	BB1	0.77
Behavior Problems	BA2	0.67
Behavior Problems	BA1	0.54
Reduced Physical Functions	PE2	1.06
Reduced Physical Functions	PE1	0.96
Reduced Physical Functions	PD2	0.97
Reduced Physical Functions	PD1	0.87
Reduced Physical Functions	PC2	0.83
Reduced Physical Functions	PC1	0.76
Reduced Physical Functions	PB2	0.73
Reduced Physical Functions	PB1	0.66
Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

(h) In place of the CMIs contained in subsection (g), the CMIs contained in this subsection shall be used for purposes of determining the facility-average CMI for Medicaid residents that meet all the following conditions:

(1) The resident classifies into one (1) of the following RUG-III groups:

(A) PB2.

(B) PB1.

(C) PA2.
(D) PA1.
(2) The resident has a cognitive status indicated by a brief interview of mental status score (BIMS) greater than or equal to ten (10) or, if there is not a BIMS score, then a cognitive performance score (CPS) of:
(A) zero (0) – Intact;
(B) one (1) – Borderline Intact; or
(C) two (2) – Mild Impairment.
(3) Based on an assessment of the resident's continence control as reported on the MDS, the resident is not experiencing occasional, frequent, or complete incontinence.
(4) The resident has not been admitted to any Medicaid-certified nursing facility before January 1, 2010.
(5) If the office ~~or its contractor~~ determines that a nursing facility has delinquent MDS resident assessments that are assigned a CMI in accordance with this subsection, then, for purposes of determining the facility's average CMI for Medicaid residents, the assessment or assessments shall be assigned ninety-six percent (96%) of the CMI associated with the RUG-III group determined in this subsection.

RUG-III Group	RUG-III Code	CMI Table
Reduced Physical Functions	PB2	0.30
Reduced Physical Functions	PB1	0.28
Reduced Physical Functions	PA2	0.24
Reduced Physical Functions	PA1	0.21

(i) The office ~~or its contractor~~ shall provide each nursing facility with the following:
(1) A preliminary CMI report that will:
(A) serve as confirmation of the MDS assessments transmitted by the nursing facility; and
(B) provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments.
The preliminary report will be provided by the twenty-fifth day of the first month following the end of a calendar quarter.
(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(j) The office will increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to the facilities at a rate of eleven dollars and fifty cents ($11.50) per Medicaid resident day. The additional reimbursement shall:
(1) be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and
(2) remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

(k) Beginning October 1, 2011, through June 30, 2013, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on the nursing home report card score. For purposes of determining the nursing home report card score rate add-on the office ~~or its contractor~~ shall determine each nursing facility's report card score based on the latest published data as of the end of the state fiscal year. The nursing home report card score rate add-on shall be computed as described in the following table:

Nursing Home Report Card Score	Nursing Home Report Card Score Rate Add-On
0 – 82	$14.30
83 – 265	$14.30 – ((Nursing Home Report Card Score – 82) × $0.0777)
266 and above	$0

Facilities that did not have a nursing home report card score published as of the most recently completed state fiscal year may receive a per patient day rate add-on equal to two dollars ($2).

(l) Through June 30, 2017, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, as demonstrated by resident assessment data as of December 31 of each year. Medicaid Alzheimer's and dementia residents shall be determined to be in the SCU based on an exact match of room numbers reported on Schedule Z with the room numbers reported on

resident assessments and tracking forms. Resident assessments and tracking forms with room numbers that are not an exact match to the room numbers reported on Schedule Z will be excluded in calculating the number of Medicaid Alzheimer's and dementia resident days in their SCU. The additional Medicaid reimbursement shall equal twelve dollars ($12) per Medicaid Alzheimer's and dementia resident day in their SCU. Only facilities that meet the definition for a SCU for Alzheimer's disease or dementia shall be eligible to receive the additional reimbursement. The additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.

(m) Through June 30, 2017, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on each facility's total quality score. For purposes of determining the nursing facility quality rate add-on, each facility's total quality score will be determined annually. Each nursing facility's quality rate add-on shall be determined as follows:

Nursing Facility Total Quality Score	Nursing Facility Quality Rate Add-On
0 – 18	$0
19 – 83	$14.30 – ((84 - Nursing Facility Total Quality Score) × 0.216667)
84 – 100	$14.30

(n) Each nursing facility shall be awarded no more than one hundred (100) quality points as determined by the following eight (8) quality measures:

(1) Nursing home report card score. The office ~~or its contractor~~ shall determine each nursing facility's quality points using the report card score published by ~~the Indiana state department of health.~~ **ISDH.** Each nursing facility shall be awarded not more than seventy-five (75) quality points based on its nursing home report card score. Each nursing facility's quality points shall be determined using each nursing facility's most recently published report card score as of June 30, 2013, and each June 30 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Home Report Card Scores	Quality Points Awarded
0 – 82	75
83 – 265	Proportional quality points awarded as follows: 75 – [(facility report card score – 82) × 0.407609]]
266 and above	0

Facilities that did not have a nursing home report card score published as of June 30, 2013, or each June 30 thereafter, shall be awarded the statewide average quality points for this measure.

(2) Normalized weighted average nursing hours per resident day. The office ~~or its contractor~~ shall determine each nursing facility's normalized weighted average nursing hours per resident day using data from its annual financial report. Nursing hours per resident day include nurse staff hours for RN, LPN, nursing assistants, and other nursing personnel categories. Nursing hours per resident day for each nurse staff category shall be weighted by the facility-specific CNA average wage rates, and normalized by dividing each facility's weighted average nursing hours per resident day by the facility's case mix index for all residents. Each nursing facility shall be awarded not more than ten (10) quality points based on the normalized weighted average nursing hours per resident day. Quality points shall be determined using each nursing facility's most recently completed annual financial report as of June 30, 2013, and each June 30 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Normalized Weighted Average Nursing Hours Per Resident Day	Quality Points Awarded
Less than or equal to 3.315	0
Greater than 3.315 and less than 4.401	Proportional quality points awarded as follows: 10 – [(4.401 – facility's normalized weighted average nursing hours per resident day) × 9.208103]
Equal to or greater than 4.401	10

Facilities that are a new operation and did not have a normalized weighted average nursing hours per resident day from the most recently completed annual financial report as of June 30, 2013, or each June 30 thereafter, shall be awarded the statewide average quality points for this measure.

(3) RN/LPN retention rate. The office ~~or its contractor~~ shall determine each nursing facility's RN/LPN retention rate using data from its Schedule X. Each nursing facility shall be awarded no more than three (3) quality points based on the facility's RN/LPN retention rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's RN/LPN Retention Rates	Quality Points Awarded
Less than or equal to 58.3%	0
Greater than 58.3% and less than 83.3%	Proportional quality points awarded as follows: 3 – [(83.3% - facility's annual RN/LPN retention rate) × 12]
Equal to or greater than 83.3%	3

Facilities that are a new operation and did not have RNs/LPNs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(4) CNA retention rate. The office ~~or its contractor~~ shall determine each nursing facility's CNA retention rate using data from its Schedule X. Each nursing facility shall be awarded no more than three (3) quality points based on the facility's CNA retention rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's CNA Retention Rates	Quality Points Awarded
Less than or equal to 49.5%	0
Greater than 49.5% and less than 76.0%	Proportional quality points awarded as follows: 3 – [(76.0% – facility's annual CNA retention rate) × 11.320755]
Equal to or greater than 76.0%	3

Facilities that are a new operation and did not have CNAs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(5) RN/LPN turnover rate. The office ~~or its contractor~~ shall determine each nursing facility's RN/LPN turnover rate using data from its Schedule X. Each nursing facility shall be awarded not more than one (1) quality point based on the facility's RN/LPN turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's Annual RN/LPN Turnover Rate	Quality Points Awarded
Less than or equal to 26.1%	1
Greater than 26.1% and less than 71.4%	Proportional quality points awarded as follows: 1 – [(26.1% – facility's annual RN/LPN turnover rate) × (-2.207506)]
Equal to or greater than 71.4%	0

Facilities that are a new operation and did not have RNs/LPNs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(6) CNA turnover rate. The office ~~or its contractor~~ shall determine each nursing facility's CNA turnover rate using data from its Schedule X. Each nursing facility shall be awarded no more than two (2) quality points based on the facility's CNA turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility Annual CNA Turnover Rates	Quality Points Awarded
Less than or equal to 39.4%	2
Greater than 39.4% and less than 96.2%	Proportional quality points awarded as follows: 2 – [39.4% – facility's annual CNA turnover rate) × (-3.521127)]
Equal to or greater than 96.2%	0

Facilities that are a new operation and did not have a CNA for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(7) Administrator turnover. The office ~~or its contractor~~ shall determine each nursing facility's administrator turnover using data from its Schedule X. The nursing facility administrator turnover shall be based on the number of nursing home administrators employed or designated by the facility during the most recent five (5) year period. A nursing facility administrator hired on a temporary basis due to a documented medical or other temporary leave of absence shall not be counted in cases where the previous administrator is reasonably expected to return to the position and whose employment or designation as facility administrator is not terminated. Any such leave of absence shall be documented to the satisfaction of the office. Each nursing

facility shall be awarded not more than three (3) quality points based on the facility's administrator turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Number of Administrators Employed Within the Last Five (5) Years	Quality Points Awarded
6 or more	0
5	1
4	2
3 or fewer	3

Facilities that did not have a facility administrator employed or designated for the previous five (5) years shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(8) Director of nursing (DON) turnover. The office ~~or its contractor~~ shall determine each nursing facility's DON turnover using data from its Schedule X. The nursing facility DON turnover shall be based on the number of DONs employed or designated by the facility during the most recent five (5) year period. A nursing facility DON hired on a temporary basis due to a documented medical or other temporary leave of absence shall not be counted in cases where the previous DON is reasonably expected to return to the position and whose employment or designation as facility DON is not terminated. Any such leave of absence shall be documented to the satisfaction of the office. Each nursing facility shall be awarded no more than three (3) quality points based on the number of DONs employed or designated by the facility during the most recent five (5) year period. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Number of DONs Employed Within the Last Five (5) Years	Quality Points Awarded
6 or more	0
5	1
4	2
3 or fewer	3

Facilities that did not have a facility DON employed or designated for the previous five (5) years shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; errata filed Feb 27, 2003, 11:33 a.m.: 26 IR 2375; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3873; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2978; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 3, 2009, 1:44 p.m.: 20090429-IR-405080602FRA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 52. 405 IAC 1-14.6-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-9 Rate components; rate limitations; profit add-on

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

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative, and capital components, plus a potential profit add-on payment as defined below. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

(1) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average CMI for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(2) The therapy component is equal to the provider's allowable Medicaid per patient day direct therapy costs.

(3) The indirect care and capital components are equal to the provider's allowable per patient day costs for

each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).
(4) The administrative component shall be equal to one hundred percent (100%) of the average allowable cost of the median patient day.

(b) The profit add-on payment will be calculated as follows:
(1) For nursing facilities designated by the office as children's nursing facilities, the allowed direct care component profit add-on is equal to the profit add-on percentage contained in Table 1, times the difference (if greater than zero (0)) between:
(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 1; minus
(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 1				
Children's Nursing Facilities				
Effective Date	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2017	July 1, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	30%	52%	110%	105%

(2) For nursing facilities that are not designated by the office as children's nursing facilities, the tentative direct care component profit add-on payment is equal to the profit add-on percentage contained in Table 2, times the difference (if greater than zero (0)) between:
(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 2; minus
(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 2				
Non-Children's Nursing Facilities				
Effective Date	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2017	July 1, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	30%	0%	110%	105%

(C) For nursing facilities not designated by the office as children's nursing facilities, the allowed direct care component profit add-on payment is equal to the facility's tentative direct care component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's total quality score.

Table 3	
Total Quality Score	Percentage
84 - 100	100%
19 - 83	100% + ((Total Quality Score – 84) / 66)
18 and below	0%

(D) In no event shall the allowed direct care profit add-on payment exceed ten percent (10%) of the average allowable cost of the median patient day.
(3) The tentative indirect care component profit add-on payment is equal to the profit add-on percentage contained in Table 4, times the difference (if greater than zero (0)) between:
(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 4; minus
(B) a provider's allowable per patient day cost.

Table 4				
Effective Date	Indirect Care Profit Add-on Percentage		Indirect Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2017	July 1, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	60%	52%	105%	100%

(C) The allowed indirect care component profit add-on payment is equal to the facility's tentative indirect care component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's total quality score.
(4) The tentative capital component profit add-on payment is equal to sixty percent (60%) times the difference

(if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 5; minus

(B) a provider's allowable per patient day cost.

Table 5		
Capital Component Profit Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	100%	80%

(C) The allowed capital component profit add-on payment is equal to the facility's tentative capital component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's total quality score.

(5) The therapy component profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate ceiling defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs times the facility-average CMI for Medicaid residents times the overall rate ceiling percentage in Table 6.

Table 6		
Direct Care Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	120%	110%

(2) The average allowable cost of the median patient day for indirect care costs times the overall rate ceiling percentage in Table 7.

Table 7		
Indirect Care Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	115%	100%

(3) The average allowable cost of the median patient day for capital-related costs times the overall rate ceiling percentage in Table 8.

Table 8		
Capital Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	100%	80%

(4) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office ~~or its contractor~~ shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines:

(1) shall be published as a provider bulletin; and

(2) may be updated by the office as needed.

Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3874; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2980; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 53. 405 IAC 1-14.6-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-10 Computation of rate; allowable costs; review of cost reasonableness

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

Sec. 10. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report forms. Allowable patient care costs shall be clearly identified.

(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers throughout the state. The office ~~or its contractors~~ may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Personal or federal income taxes are not considered allowable costs.

(e) The following costs are not considered allowable costs and shall not be included in the established rate:
(1) All over-the-counter, legend, and nonlegend drugs.
(2) Cost of replacement hearing aids and eyeglasses.
(3) All costs associated with pastoral care.
(4) All costs associated with resident and family gifts, including, but not limited to, flowers, Bibles, and memory books.
(5) All costs associated with collection fees.
(6) All costs, fees, and dues associated with lobbying activities.
(7) All costs of acquisitions, such as the purchase of corporate stock as an investment or purchases of new facilities.
(8) All costs associated with barber and beauty shop activities.
(9) All costs associated with marketing.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-10; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 54. 405 IAC 1-14.6-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-16 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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

Sec. 16. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient-related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

(d) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services and are required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office ~~or its contractor~~ shall

remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office ~~or its contractor~~ shall calculate a ratio of indirect cost to direct cost based on the direct and total therapy and nonallowable ancillary costs reported on each facility's Medicare cost report.

(e) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services that are not required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office ~~or its contractor~~ shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office ~~or its contractor~~ shall remove the indirect and administrative costs reimbursed by other payers based on a statewide average ratio, excluding hospital based facilities, of indirect costs to direct costs for such therapy and ancillary services, as determined from full Medicare cost reports. The statewide average ratio shall be computed on a statewide basis from the most recently completed desk reviewed annual financial report and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-16; filed Aug 12, 1998, 2:27 p.m.: 22 IR 79, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3875; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 55. 405 IAC 1-14.6-19 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-19 Medical or nonmedical supplies and equipment

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

Sec. 19. The approved per diem rate in nursing facilities includes the cost of both medical and nonmedical supply items, and the provider shall not bill ~~the~~ Medicaid ~~program~~ for such items in addition to the established rate. Under no circumstances shall medical or nonmedical supplies and equipment for nursing facility residents be billed through a pharmacy or other provider. Medical and nonmedical supply items for nursing facility residents that are reimbursed by other payor sources shall not be reimbursed by Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-19; filed Aug 12, 1998, 2:27 p.m.: 22 IR 80, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 56. 405 IAC 1-14.6-20 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-20 Nursing facilities reimbursement for therapy services

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

Sec. 20. (a) Therapy services provided to Medicaid ~~recipients~~ **members** by nursing facilities are included in the established rate. Under no circumstances shall therapies for nursing facility residents be billed to Medicaid through any provider. Therapy services for nursing facility residents that are reimbursed by other payor sources shall not be reimbursed by Medicaid.

(b) For purposes of determining allowable therapy costs, the office ~~or its contractor~~ shall adjust each provider's cost of therapy services reported on the Nursing Facility Financial Report, including any employee benefits prorated based on total salaries and wages, to account for non-Medicaid payers, including Medicare, of therapy services provided to nursing facility residents. Such adjustment shall be applied to each cost report in order to remove reported costs attributable to therapy services reimbursed by other payers. The adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-20; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81,

eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 57. 405 IAC 1-14.6-22 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Authority: IC 12-15-1-10; IC 12-15-21-3
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15

Sec. 22. (a) The ~~Medicaid rate-setting contractor~~ **office** shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate the provider may request an administrative reconsideration by the ~~Medicaid rate-setting contractor.~~ **office.** Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the ~~contractor~~ **office** not later than forty-five (45) days after release of the rate as computed by the ~~Medicaid rate-setting contractor.~~ **office.** Upon receipt of the request for reconsideration, the ~~Medicaid rate-setting contractor~~ **office** shall evaluate the data. After review, the ~~Medicaid rate-setting contractor~~ **office** may amend the rate, amend the challenged procedure, or affirm the original decision. The ~~Medicaid rate-setting contractor~~ **office** shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the ~~Medicaid rate-setting contractor's~~ **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the ~~rate-setting contractor~~ **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

(b) If the provider disagrees with the preliminary recalculated Medicaid rate resulting from a financial audit adjustment or reportable condition the provider may request an administrative reconsideration from the ~~Medicaid audit contractor.~~ **office.** Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or authorized representative of the provider and must be received by the ~~Medicaid audit contractor~~ **office** not later than forty-five (45) days after release of the preliminary recalculated Medicaid rate computed by the ~~Medicaid rate-setting contractor.~~ **office.** Upon receipt of the request for reconsideration, the ~~Medicaid audit contractor~~ **office** shall evaluate the data. After review, the ~~Medicaid audit contractor~~ **office** may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The ~~Medicaid audit contractor~~ **office** shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the ~~Medicaid audit contractor's~~ **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the ~~audit contractor~~ **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider may request an administrative reconsideration from the ~~Medicaid rate-setting contractor.~~ **office.** Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or authorized representative of the provider and must be received by the ~~Medicaid rate-setting contractor~~ **office** not later than forty-five (45) days after release of the rate computed by the ~~Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall forward the administrative reconsideration to the MDS audit contractor who shall evaluate the data.~~ **office.** After review, the ~~MDS audit contractor~~ **office** may amend the audit adjustment or affirm the original adjustment. The ~~MDS audit contractor~~ **office** shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the ~~Medicaid rate-setting contractor's~~ **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the ~~Medicaid rate-setting contractor~~ **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal must be signed by the nursing facility provider.

(e) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-22; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; errata filed Jul 28, 1999, 3:10 p.m.: 22 IR 3937; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3876; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 58. 405 IAC 1-14.6-24 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-24 Nursing facility quality assessment

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15-21-3; IC 16-21; IC 16-28-15-2; IC 16-28-15-7; IC 23-2-4

Sec. 24. (a) Through June 30, 2017, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility based on the most recently completed annual financial report or quality assessment data collection form, as follows:

(1) Privately owned or operated nursing facilities with total annual nursing facility census days fewer than sixty-two thousand (62,000), sixteen dollars and thirty-seven cents ($16.37) per non-Medicare day.

(2) Privately owned or operated and nonstate government owned or operated nursing facilities with total annual nursing facility census days equal to or greater than sixty-two thousand (62,000), four dollars and nine cents ($4.09) per non-Medicare day.

(3) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated before July 1, 2003, four dollars and nine cents ($4.09) per non-Medicare day.

(4) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated on or after July 1, 2003, with total annual nursing facility census fewer than sixty-two thousand (62,000), sixteen dollars and thirty-seven cents ($16.37) per non-Medicare day.

(b) Under IC 16-28-15-7(2), the following nursing facilities shall be exempt from the quality assessment described in subsection (a):

(1) A continuing care retirement community that meets one (1) of the following:

(A) A continuing care retirement community that was registered with the securities commissioner as a continuing care retirement community on or before January 1, 2007, and that has continuously maintained at least one (1) continuing care agreement since on or before January 1, 2007, with an individual residing in the continuing care retirement community.

(B) A continuing care retirement community that for the entire period from January 1, 2007, through June 30, 2009, operated independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars ($25,000).

(C) An organization registered under IC 23-2-4 before July 1, 2009, that provides housing in an independent living unit for a religious order.

(D) A continuing care retirement community that meets the definition set forth in IC 16-28-15-2.

(2) A hospital-based nursing facility licensed under IC 16-21.

(3) The Indiana Veterans' Home.

(c) For nursing facilities certified for participation in ~~the~~ Medicaid ~~program~~ under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the quality assessment shall be an allowable cost for cost reporting and auditing purposes. The quality assessment shall be included in Medicaid reimbursement as an add-on to the Medicaid rate. The add-on is determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk reviewed annual financial report.

(d) For nursing facilities that are not certified for participation in ~~the~~ Medicaid ~~program~~ under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the facility shall remit the quality assessment to the state of

Indiana within ten (10) days after the due date. If a nursing facility fails to pay the quality assessment under this subsection within ten (10) days after the date the payment is due, the nursing facility shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(e) The office ~~or its contractor~~ shall notify each nursing facility of the amount of the facility's assessment after the amount of the assessment has been computed. If the facility disagrees with the computation of the assessment, the facility shall request an administrative reconsideration by the ~~Medicaid rate-setting contractor.~~ **office.** The reconsideration request shall be as follows:

(1) In writing.

(2) Contain the following:

(A) Specific issues to be reconsidered.

(B) The rationale for the facility's position.

(3) Signed by the authorized representative of the facility and must be received by the ~~contractor~~ **office** not later than forty-five (45) days after the notice of the assessment is mailed.

Upon receipt of the request for reconsideration, the ~~Medicaid rate-setting contractor~~ **office** shall evaluate the data. After review, the ~~Medicaid rate-setting contractor~~ **office** may amend the assessment or affirm the original decision. The ~~Medicaid rate-setting contractor~~ **office** shall thereafter notify the facility of its final decision in writing, within forty-five (45) days of the ~~Medicaid rate-setting contractor's~~ **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the ~~rate-setting contractor~~ **office** to the facility's reconsideration request, the request shall be deemed denied and the provider may initiate an appeal under IC 4-21.5-3.

(f) The assessment shall be calculated on an annual basis with equal monthly amounts due on or before the tenth day of each calendar month.

(g) A facility may file a request to pay the quality assessment on an installment plan. The request shall be as follows:

(1) In writing setting forth the facility's rationale for the request.

(2) Submitted to the office. ~~or its designee.~~

An installment plan established under this section shall not exceed a period of six (6) months from the date of execution of the agreement. The agreement shall set forth the amount of the assessment that shall be paid in installments and include provisions for the collection of interest. The interest shall not exceed the percentage set out in IC 12-15-21-3(6)(A).

(h) A facility that fails to pay the quality assessment due under this section within ten (10) days after the date the payment is due shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(i) The office shall offset the collection of the assessment fee for a facility as follows:

(1) Against a Medicaid payment to the facility.

(2) Against a Medicaid payment to another health facility that is related to the facility through common ownership or control.

(3) In another manner determined by the office.

(j) If a facility:

(1) fails to submit patient day information requested by the office to calculate the quality assessment fee; or

(2) fails to pay the quality assessment fee;

not later than one hundred twenty (120) days after the patient day information is requested, or payment of the quality assessment is due, the office shall report each facility to ~~the state department of health~~ **ISDH** to initiate license revocation proceedings in accordance with IC 16-28-15-12.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-24; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2983; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:45 a.m.: 20101201-IR-405100065FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 59. 405 IAC 1-15-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-1 Scope

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

Sec. 1. This section requires nursing facilities certified to provide nursing facility care to Medicaid ~~recipients~~ **members** to electronically transmit minimum data set (MDS) information for all residents, including residents in a noncertified bed, to the office ~~of Medicaid policy and planning~~ for use in establishing and maintaining a case mix reimbursement system for Medicaid payments to nursing facilities and other Medicaid program management purposes.

(Office of the Secretary of Family and Social Services; 405 IAC 1-15-1; filed Nov 1, 1995, 8:30 a.m.: 19 IR 350; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 60. 405 IAC 1-15-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-2 Definitions

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

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

(b) "Case mix reimbursement" means a system of paying nursing facilities according to the mix of residents in each facility as measured by resident characteristics and service needs. Its function is to provide payment for resources needed to serve different types of residents.

(c) "Minimum data set" **or "MDS"** means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in ~~the~~ Medicaid. ~~program.~~ The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies. Version 2.0 (9/2000) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by ~~the Centers for Medicare and Medicaid Services~~ CMS.

~~(d) "Office" means the office of Medicaid policy and planning.~~

(Office of the Secretary of Family and Social Services; 405 IAC 1-15-2; filed Nov 1, 1995, 8:30 a.m.: 19 IR 350; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 61. 405 IAC 1-15-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-3 General requirements

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

Sec. 3. (a) The office shall provide nursing facilities with technical support in preparing MDS transmission to the office, ~~or its contractor,~~ including, but not limited to, the following:
(1) Providing training on the transmission of MDS data.
(2) Any other support that the office deems necessary for successful transmission of MDS data.

(b) Allowable costs incurred by nursing facilities relating to transmission of MDS data to the office shall be reimbursed through the cost reporting mechanism established under 405 IAC 1-14.6.

(Office of the Secretary of Family and Social Services; 405 IAC 1-15-3; filed Nov 1, 1995, 8:30 a.m.: 19 IR 351; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 62. 405 IAC 1-15-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-5 MDS audit requirements

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

Sec. 5. (a) The office ~~or its contractor~~ shall periodically audit the MDS supporting documentation maintained by nursing facilities for all residents, regardless of payer type. The audits shall be conducted as frequently as deemed necessary by the office, and each nursing facility shall be audited no less frequently than every thirty-six (36) months. Advance notification of up to seventy-two (72) hours shall be provided by the office ~~or its contractor~~ for all MDS audits, except for follow-up audits that are intended to ensure compliance with validation improvement plans. Advance notification for follow-up audits shall not be required.

(b) All MDS assessments, regardless of payer type, are subject to an MDS audit.

(c) When conducting the MDS audits, the office ~~or its contractor~~ shall consider all MDS supporting documentation that is provided by the nursing facility and is available to the auditors prior to the exit conference. MDS supporting documentation that is provided by the nursing facility after the exit conference shall not be considered by the office.

(d) The nursing facility shall be required to produce, upon request by the office ~~or its contractor,~~ a computer generated copy of the MDS assessment that is transmitted in accordance with section 1 of this rule, which shall be the basis for the MDS audit.

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments have been transmitted, shall be referred to the ~~Medicaid fraud control unit (MFCU) of the Indiana attorney general's office~~ **IMFCU** for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction.

(Office of the Secretary of Family and Social Services; 405 IAC 1-15-5; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2249; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 63. 405 IAC 1-16-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-16-1 Policy

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid ~~recipients~~ **members** by duly certified hospice providers that provide hospice care. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:
(1) Proper and current certification.
(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, and compensate providers for reasonable, allowable costs that must be incurred by efficiently and economically operated facilities. The system of payment outlined in this rule is a

prospective system.

(Office of the Secretary of Family and Social Services; 405 IAC 1-16-1; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2377; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 64. 405 IAC 1-16-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-16-2 Levels of care

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 2. (a) Reimbursement for hospice care shall be made according to the methodology and amounts calculated by ~~the Centers for Medicare and Medicaid Services~~ CMS. ~~formerly the Health Care Financing Administration (HCFA).~~ Medicaid hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates will be adjusted for regional differences in wages using the geographical areas defined by CMS and hospice wage index published by CMS.

(b) Medicaid reimbursement for hospice services will be made at one (1) of four (4) all-inclusive per diem rates for each day in which a Medicaid ~~recipient~~ **member** is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:
(1) Routine home care.
(2) Continuous home care.
(3) Inpatient respite care.
(4) General inpatient hospice care.

(c) The hospice will be paid at the routine home care rate for each day the ~~recipient~~ **member** is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(d) Continuous home care is to be provided only during a period of crisis. A period of crisis is defined as a period in which a patient requires continuous care that is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse, and a nurse must provide care for over half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day that begins and ends at midnight. This care need not be continuous and uninterrupted. The continuous home care rate is divided by twenty-four (24) hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty-four (24) hours a day.

(e) The hospice provider will be paid at the inpatient respite care rate for each day that the ~~recipient~~ **member** is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the ~~recipient~~ **member** only when necessary to relieve the family members or other persons caring for the ~~recipient.~~ **member.** Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) consecutive days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(f) Subject to the limitations in section 3 of this rule, the hospice provider will be paid at the general inpatient hospice rate for each day the ~~recipient~~ **member** is in an approved inpatient hospice facility and is receiving services related to the terminal illness. The ~~recipient~~ **member** must require general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings. Documentation in the ~~recipient's~~ **member's** record must clearly explain the reason for admission and the ~~recipient's~~ **member's** condition during the stay in the facility at this level of care. No other fixed payment rate (i.e., routine home care) will be made for a day on which the patient receives general hospice inpatient care. Services provided in the inpatient setting must conform to the hospice patient's plan of care. The hospice provider is the professional manager of the patient's care, regardless of the physical setting of that care or the level of care. If the inpatient facility is not also the hospice provider, the hospice provider must have a contract with the inpatient facility

delineating the roles of each provider in the plan of care.

(g) When routine home care or continuous home care is furnished to a ~~recipient~~ **member** who resides in a nursing facility, the nursing facility is considered the ~~recipient's~~ **member's** home.

(h) Reimbursement for inpatient respite care is available only for a ~~recipient~~ **member** who resides in a private home. Reimbursement for inpatient respite care is not available for a ~~recipient~~ **member** who resides in a nursing facility.

(i) When a ~~recipient~~ **member** is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge.

(Office of the Secretary of Family and Social Services; 405 IAC 1-16-2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2377; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3634; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 65. 405 IAC 1-16-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-16-3 Limitation on payments for inpatient care

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 3. (a) Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid ~~recipients.~~ **members.** During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid ~~recipients~~ **members** during the same period by the designated hospice provider or its contracted agent or agents. For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice provider receives payment at a home care rate will not be counted as inpatient days.

(b) The limitations on payment for inpatient days are as follows:
(1) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).
(2) If the total number of days of inpatient care to Medicaid hospice ~~recipients~~ **members** is less than or equal to the maximum number of inpatient days computed in subdivision (1), then no adjustment is made.
(3) If the total number of days of inpatient care to Medicaid hospice ~~recipients~~ **members** is greater than the maximum number of inpatient days computed in subdivision (1), then the payment limitation will be determined by the following method:
(A) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made.
(B) Multiplying excess inpatient care days by the routine home care rate.
(C) Adding together the amounts calculated in clauses (A) and (B).
(D) Comparing the amount in clause (C) with total reimbursement made to the hospice provider for inpatient care during the cap period. The amount by which total reimbursement made to the hospice provider for inpatient care for Medicaid ~~recipients~~ **members** exceeds the amount calculated in clause (C) is due from the hospice provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-16-3; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 66. 405 IAC 1-16-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-16-4 Additional amount for nursing facility residents

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 4. (a) An additional per diem amount will be paid directly to the hospice provider for room and board of hospice residents in a certified nursing facility receiving routine or continuous care services, when the office has determined that the ~~recipient~~ **member** requires nursing facility level of care. Medicaid reimbursement is available for hospice services rendered to a nursing facility resident only if, prior to services being rendered, the hospice and the nursing facility enter into a written agreement under which the hospice takes full responsibility for the professional care management of the resident's hospice care and the nursing facility agrees to provide room and board to the individual. In this context, "room and board" includes all assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

(b) The room and board rate will be ninety-five percent (95%) of the lowest per diem reimbursement rate ~~Indiana~~ Medicaid would have paid to the nursing facility for any resident for those dates of service on which the ~~recipient~~ **member** was a resident of that facility.

(c) Medicaid payment to the nursing facility for nursing facility care for the hospice resident is discontinued when the resident makes an election to receive hospice care. Any payment to the nursing facility for furnishing room and board to hospice patients is made by the hospice provider under the terms of its agreement with the nursing facility.

(d) The additional amount for room and board is not available for ~~recipients~~ **members** receiving inpatient respite care or general inpatient care.

(Office of the Secretary of Family and Social Services; 405 IAC 1-16-4; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 67. 405 IAC 1-16-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-16-5 Reimbursement for physician services

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 5. (a) The basic payment rates for hospice care represent full reimbursement to the hospice provider for the costs of all covered services related to the treatment of the ~~recipient's~~ **member's** terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice provider. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for hospice care.

(b) Reimbursement for a hospice employed physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual ~~Indiana~~ Medicaid reimbursement methodology for physician services. These services will be billed by the hospice provider under the Medicaid hospice provider number. The only physician services to be billed separately from the hospice per diem are direct patient care services. Laboratory and x-ray services relating to the terminal condition are included in the hospice daily rate.

(c) Reimbursement for an independent physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual ~~Indiana~~ Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice provider under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to ~~the~~

Medicaid ~~program~~ when those services relate to the terminal condition. These costs are included in the daily rates paid and are expressly the responsibility of the hospice provider.

(d) Volunteer physician services are excluded from Medicaid reimbursement. However, a physician who provides volunteer services to a hospice may be reimbursed for nonvolunteer services provided to hospice patients. In determining which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid patients on the same basis as other hospice patients. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment for all physician services rendered to Medicaid patients.

(Office of the Secretary of Family and Social Services; 405 IAC 1-16-5; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 68. 405 IAC 1-17-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-1 Policy; scope

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-3.5; IC 12-15-13-4; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid ~~recipients~~ **members** by duly certified state-owned ~~intermediate care facilities for the mentally retarded (ICF/MR),~~ **ICFs/IID,** state-owned nursing facilities, and state-owned psychiatric hospitals. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.
(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures:

(1) recognize level and quality of care;
(2) establish effective accountability over Medicaid expenditures;
(3) provide for a regular review mechanism for rate changes;
(4) compensate providers for reasonable, allowable costs incurred by a prudent businessperson; and
(5) allow incentives to encourage efficient and economic operations.

The system of payment outlined in this rule is a retrospective system using interim rates predicated on a reasonable, cost-related basis, in conjunction with a final settlement process. Cost limitations are contained in this rule that establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data that caused a rate higher than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must:

(1) complete the appropriate Medicaid billing adjustment form; and
(2) reimburse the office for the amount of the overpayment.

(d) The office may implement Medicaid rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the office to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the office, providing the provider avails itself of the opportunity to make such an appeal. Interest shall be assessed in accordance with ~~IC 12-15-13-3~~. **IC 12-15-13-3.5(g) for a noninstitutional provider or IC 12-15-13-4(h) for an institutional provider.**

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-1; filed Sep 1, 1998, 3:25 p.m.: 22 IR 83; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 93; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jun 28, 2010, 2:21 p.m.: 20100728-IR-405090192FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 69. 405 IAC 1-17-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-2 Definitions

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

(b) "All-inclusive rate" means a per diem rate which, at a minimum, reimburses for all:
(1) nursing care;
(2) room and board;
(3) supplies; and
(4) ancillary therapy services;
within a single, comprehensive amount.

(c) "Annual, historical, or budget financial report" refers to a presentation of financial data, including accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or the changes therein for a period of time in compliance with the reporting requirements of this rule which shall constitute a comprehensive basis of accounting.

(d) "Budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

(e) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(f) "Desk review" means a review and application of this rule to a provider submitted annual financial report including accompanying notes and supplemental information.

(g) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(h) "Forms prescribed by the office" means:
(1) forms provided by the office; or
(2) substitute forms that have received prior written approval by the office.

(i) "General line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(j) "Generally accepted accounting principles" means those accounting principles as established by the Governmental Accounting Standards Board (GASB).

~~(k) "ICF/MR" means intermediate care facilities for the mentally retarded.~~

~~(l)~~ **(k)** "Like levels of care" means ~~ICF/MR~~ **ICF/IID** level of care provided in a state-owned ~~ICF/MR,~~ **ICF/IID,** nursing facility level of care provided in a state-owned nursing facility, or psychiatric hospital level of care provided in a state-owned psychiatric hospital.

~~(m) "Office" means the office of Medicaid policy and planning.~~

~~(n)~~ **(l)** "Ordinary patient related costs" means costs of services and supplies that are necessary in the delivery of patient care by similar providers within the state.

~~(o)~~ **(m)** ~~"Patient/recipient~~ **"Patient/member** care" means those Medicaid program services delivered to a Medicaid enrolled ~~recipient~~ **member** by a ~~certified Medicaid~~ provider.

~~(p)~~ **(n)** "Reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

~~(q)~~ **(o)** "Unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-2; filed Sep 1, 1998, 3:25 p.m.: 22 IR 83; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 94; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jun 28, 2010, 2:21 p.m.: 20100728-IR-405090192FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 70. 405 IAC 1-17-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-4 Financial report to office; annual schedule; prescribed form; extensions

Authority: 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. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient related interest bearing debt.
(6) Schedule of Medicaid and private pay charges; private pay charges shall be lowest usual and ~~ordinary~~ **customary** charge on the last day of the reporting period.
(7) Certification by the provider that the data are true, accurate, related to patient care, and that expenses not related to patient care have been clearly identified.
(8) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-4; filed Sep 1, 1998, 3:25 p.m.: 22 IR 85; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 95; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 71. 405 IAC 1-17-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-7 Request for rate review; budget component; occupancy level assumptions; effect of

inflation assumptions

Authority: 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. 7. Under this rate setting system, emphasis is placed on proper planning, budgeting, and cost control by the provider. To establish consistency in the submission and review of forecasted costs, the following apply:

(1) Each interim rate review request shall include a budget financial report. If a budget financial report is not submitted, the interim rate review will not result in an increase in Medicaid rates but may result in a rate decrease based on historical or annual financial reports submitted.

(2) All budget financial reports shall be submitted using forms prescribed by the office. All forecasted data and required attachments shall be completed to provide full financial disclosure and will include as a minimum the following:

(A) Patient census data.

(B) Statistical data.

(C) Ownership and related party information.

(D) Statement of all expenses and all income.

(E) Detail of fixed assets and patient related interest bearing debt.

(F) Schedule of Medicaid and private pay charges; charges shall be the lowest usual and ~~ordinary~~ **customary** charge on the rate effective date of the rate review.

(G) Certification by the provider that forecasted data has been prepared in good faith, with appropriate care by qualified personnel, using appropriate accounting principles and assumptions, and that the process to develop the forecasted data uses the best information that is reasonably available and is consistent with the plans of the provider. The certification shall state that all expenses not related to patient care have been clearly identified or removed.

(H) Certification by the preparer, if the preparer is different from the provider, that the forecasted data were compiled from all information provided to the preparer and that the preparer has read the forecasted data with its summaries of significant assumptions and accounting policies and has considered them to be not obviously inappropriate.

(3) The provider shall adjust patient census data based on the highest of the following:

(A) Historical patient days for the most recent historical period unless the provider can justify the use of a lower figure for the patient days.

(B) Forecasted patient days for the twelve (12) month budget period.

(4) The provider and the office shall recognize and adjust forecasted data accordingly for the inflationary or deflationary effect on historical data for the period between the midpoint of the historical or annual financial report time period and the midpoint of the budget financial report. Forecasted data may be adjusted based upon reasonably anticipated rates of inflation.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-7; filed Sep 1, 1998, 3:25 p.m.: 22 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 97; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 72. 405 IAC 1-17-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-17 State-owned facilities per diem rate

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

Sec. 17. (a) The per diem rate for providers reimbursed under this rule:

(1) is an all-inclusive rate; and

(2) includes all services provided to ~~recipients~~ **members** by the facility.

(b) Resources from health insurance plans available to the resident shall apply first to defraying the costs of medical services before Medicaid. Such resources shall include, but not be limited to, Medicare, Civilian Health and Medical Plan for Uniform Services, Veteran's Administration, and other health insurances. Services reimbursed through other sources shall be segregated and not claimed on the facility's cost report.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-17; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA;

readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 73. 405 IAC 1-17-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-18 Administrative reconsideration; appeal

Authority: 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. 18. (a) The ~~Medicaid rate setting contractor~~ **office** shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the ~~Medicaid rate setting contractor.~~ **office.** Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the ~~contractor~~ **office** within forty-five (45) days after release of the rate computed by the ~~Medicaid rate setting contractor.~~ **office.** Upon receipt of the request for reconsideration, the ~~Medicaid rate setting contractor~~ **office** shall evaluate the data. After review, the ~~Medicaid rate setting contractor~~ **office** may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The ~~Medicaid rate setting contractor~~ **office** shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the ~~Medicaid rate setting contractor's~~ **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the ~~rate setting contractor~~ **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with a rate redetermination resulting from an audit adjustment, the provider must request an administrative reconsideration from the ~~Medicaid audit contractor.~~ **office.** Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider and must be received by the ~~Medicaid audit contractor~~ **office** within forty-five (45) days after release of the rate computed by the ~~Medicaid rate setting contractor.~~ **office.** Upon receipt of the request for reconsideration, the ~~Medicaid audit contractor~~ **office** shall evaluate the data. After review, the ~~Medicaid audit contractor~~ **office** may amend the audit adjustment or affirm the original adjustment. The ~~Medicaid audit contractor~~ **office** shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the ~~Medicaid audit contractor's~~ **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the ~~audit contractor~~ **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under 405 IAC 1-1.5.

(d) The office may take action to prospectively implement Medicaid rates without awaiting the outcome of the administrative process.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-18; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 74. 405 IAC 1-18-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-18-2 Reimbursement of cross-over claims

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-14

Sec. 2. (a) Cross-over claims filed by ~~Medicaid~~ providers are reimbursed as set out in this section.

(b) If the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero (0).

(c) If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:
(1) the difference between the Medicaid allowable amount minus the Medicare payment amount; or
(2) the Medicare coinsurance and deductible, if any, for the claim.

(Office of the Secretary of Family and Social Services; 405 IAC 1-18-2; filed Mar 18, 2002, 3:32 p.m.: 25 IR 2477; filed Nov 27, 2002, 4:30 p.m.: 26 IR 1079; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 75. 405 IAC 1-19-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-19-2 Time and manner of disclosure

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

Sec. 2. (a) Any disclosing entity that is a long term care facility must supply the information specified in this rule to ~~the Indiana state department of health~~ **ISDH** at the time it is surveyed.

(b) Any disclosing entity must supply the information specified in this rule to the office ~~or its fiscal agent~~ at any time there is a change in ownership or control.

(c) Any provider must supply the information specified in this rule at the time of filing a complete application.

(d) Any provider must supply the information specified in this rule upon executing the provider agreement.

(e) Providers are required to notify the office upon such time as the information specified in this rule changes within thirty-five (35) days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall also provide notification in accordance with 405 IAC 1-20. New nursing facility providers are required to notify the office in accordance with this rule and 405 IAC 1-14.6-5.

(Office of the Secretary of Family and Social Services; 405 IAC 1-19-2; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2865; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 76. 405 IAC 1-20-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-20-1 General

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

Sec. 1. (a) As used in 405 IAC 1-19 and this rule, "long term care facility" means any of the following:
(1) A nursing facility.
(2) A ~~community residential facility for the developmentally disabled.~~ **CRF/DD.**
(3) An ~~intermediate care facility for the mentally retarded.~~ **ICF/IID.**

(b) For Medicaid provider agreement purposes, the provider is the party directly or ultimately responsible for operating the business enterprise. This party is legally responsible for decisions and liabilities in a business management sense. The same party also bears the final responsibility for operational decisions made in the capacity of a governing body and for the consequences of those decisions.

(c) Whether the owner of the provider enterprise (provider) owns the premises or rents or leases the premises from a landlord or lessor is immaterial. However, if the provider enters into an agreement, which allows the landlord to make or participate in decisions about the ongoing operation of the provider enterprise, this indicates that the provider has entered into either a partnership agreement or a management agency agreement instead of a property lease. A new partnership agreement constitutes a change of ownership.

(Office of the Secretary of Family and Social Services; 405 IAC 1-20-1; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2866; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 77. 405 IAC 1-20-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-20-2 Notification requirements

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

Sec. 2. (a) When a change of ownership in a long term care facility is contemplated, the transferor provider shall notify the office, or its fiscal agent, no less than forty-five (45) days prior to the effective date of sale or lease agreement that a change of ownership may take place.

(b) Notification shall be in writing and include the following:
(1) A copy of the agreement of sale or transfer.
(2) The expected date of transfer.
(3) If applicable, the name of any individual who has an ownership or control interest, is a managing employee, or an agent of the transferor, who will also hold an ownership or control interest, be a managing employee, or be an agent of the transferee.

(c) The transferee shall make application to the office for an amendment to the transferor's provider agreement no less than forty-five (45) days prior to the expected date of transfer in accordance with this rule and 405 IAC 1-14.6-5(c).

(d) If notification requirements from both the transferor and the transferee have not been met on or before the forty-fifth day before the effective date of the change of ownership, all Medicaid payments due to the transferor may be held until such time as the information is received, reviewed, and approved for completeness. Any payments held will not be paid, until such time as the transferee has fulfilled enrollment requirements in ~~the~~ Medicaid ~~program~~ as set forth in the provider manual and provider enrollment packet.

(e) The effective date of the change of ownership will be determined by ~~the Indiana state department of health's~~ **ISDH's** certification and transmittal and amended by ~~the Indiana state department of health,~~ **ISDH,** if necessary, to correspond with the transferor/transferee agreement of sale or transfer.

(Office of the Secretary of Family and Social Services; 405 IAC 1-20-2; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2866; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 78. 405 IAC 1-20-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-20-4 Change of ownership effect

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

Sec. 4. When there is a change of ownership of a long term care facility, the office will transfer the provider agreement to the transferee subject to the terms and conditions under which it was originally issued and subject to any existing plan of correction and pending audit findings as follows:
(1) The transferor and transferee shall reach an agreement between themselves concerning Medicaid reimbursements, underpayments, overpayments, and civil monetary penalties.
(2) From the effective date of change of ownership and if all requirements are met, all reimbursements will be made to the transferee, regardless of whether the reimbursement was incurred by a current owner or previous owner.
(3) From the effective date of change of ownership, the transferee shall assume liability for repayment to the office of any amount due the office, regardless of whether liability was incurred by a current owner or operator or by a previous owner or operator.

(4) Liability of current and previous providers to the office shall be joint and several.
(5) A current or previous owner or lessee may request from the office a list of all known outstanding liabilities due the office by the facility and of any known pending office actions against a facility that may result in further liability.
(6) For purposes of this section, examples of reimbursements, overpayments, and penalties shall include, but not be limited to, the following:
(A) Outstanding claims.
(B) Any retro rate adjustment that results in an underpayment or overpayment based upon the transferor's cost report.
(C) Amounts identified during past, present, or future audits that pertain to an audit period prior to a change in ownership.
(D) Pending or completed surveillance utilization review (SUR) audit.
(E) Imposition of penalties due to failure of the provider to be in substantial compliance with applicable federal requirements for nursing facilities participation in the Medicare **program** or Medicaid. ~~program.~~
(F) Civil monetary penalties.
(G) Amounts established by final administrative decisions.

(Office of the Secretary of Family and Social Services; 405 IAC 1-20-4; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2867; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 79. 405 IAC 1-21-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-21-1 Purpose; scope

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 1. The purpose of this section is to establish a prospective, cost-based reimbursement methodology for services provided by psychiatric residential treatment facilities that are covered by ~~the state of Indiana~~ Medicaid. ~~program.~~ Prospective payment shall constitute full reimbursement. There shall be no year-end cost settlement payments.

(Office of the Secretary of Family and Social Services; 405 IAC 1-21-1; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2475; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 80. 405 IAC 1-21-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-21-3 Reimbursement rates

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 3. Covered inpatient psychiatric facility services for individuals under twenty-one (21) years of age provided in PRTFs shall be reimbursed in accordance with the following:
(1) The PRTFs shall be reimbursed for services provided to Medicaid ~~recipients~~ **members** based upon the lower of:
(A) the statewide PRTF prospective per diem rate calculated by the office; or
(B) the usual and customary daily charges billed for the psychiatric treatment of eligible ~~recipients.~~ **members.**
(2) The applicable PRTF payment per diem rate determined in subdivision (1) shall provide reimbursement for all Medicaid covered services provided in the psychiatric residential treatment facility except for those costs described in subdivisions (3) and (6). Providers will include, and rates will be determined using, only those allowable costs as listed in Medicaid provider reimbursement manuals and update bulletins.
(3) The per diem rate determined in subdivision (1) shall exclude those costs incurred for the following:
(A) Pharmaceutical supplies and services. Medicaid reimbursement for costs incurred for pharmaceutical supplies and services provided to eligible ~~recipients~~ **members** shall be paid separate and apart from the PRTF per diem rate and in accordance with the reimbursement policies described in 405 IAC 5-24.
(B) Physician services. Medicaid reimbursement for costs incurred for physician services provided to eligible ~~recipients~~ **members** shall be paid separate and apart from the PRTF per diem rate and in accordance with

the reimbursement policies described in 405 IAC 5-25.

(4) All costs utilized to determine the statewide prospective per diem rate in subdivision (1)(A) shall be subject to reasonability standards as set forth in the Medicare Provider Reimbursement Manual, CMS-Pub. 15-1, Chapter 25.

(5) The per diem rate determined in subdivision (1) shall exclude such costs unrelated to providing psychiatric residential services, including, but not limited to, the following:

(A) Group education, including elementary and secondary education.

(B) Advertising or marketing.

(C) Nonpsychiatric specialty programs.

(6) Medicaid reimbursement for Medicaid covered psychiatric services provided to ~~recipients~~ **members** residing in a psychiatric residential treatment facility shall be limited to the payments described in this rule. Costs for Medicaid covered services not related to the ~~recipient's~~ **member's** psychiatric condition but performed at the PRTF will be included in the PRTF per diem rate. Medicaid reimbursement for Medicaid covered services not related to the ~~recipient's~~ **member's** psychiatric condition is available, separate from the PRTF per diem, only in instances where those services are unavailable at the PRTF and are performed at a location other than the PRTF.

(7) The established per diem rate for psychiatric residential treatment facilities shall be reviewed annually by the ~~OMPP or its contractor~~ **office** by using the most recent, reliable claims data and adjusted cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing inpatient psychiatric services, and adjusted as necessary, in accordance with this section.

(Office of the Secretary of Family and Social Services; 405 IAC 1-21-3; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2475; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 81. 405 IAC 1-21-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-21-4 Cost reports and audits

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 4. PRTFs shall file a cost report annually using a uniform cost report form prescribed by the office. ~~of Medicaid policy and planning (OMPP).~~ The ~~OMPP or its contractor~~ **office** may audit or review the cost reports as it deems necessary.

(Office of the Secretary of Family and Social Services; 405 IAC 1-21-4; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476; errata filed Apr 8, 2004, 10:35 a.m.: 27 IR 2499; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 82. 405 IAC 5-1-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-1-1 Intent and purpose

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

Sec. 1. (a) Under IC 12-7-1-1, Title XIX of the federal Social Security Act, and federal regulations adopted thereunder (as adopted by IC 12-13-7-3), the office ~~of Medicaid policy and planning (office),~~ with the advice of its medical staff, hereby adopts and promulgates this article to:

(1) interpret and implement the provisions of IC 12-15-5-1 and IC 12-15-21-3;

(2) ensure the efficient, economical, and medically reasonable operation of a medical assistance program (hereinafter referred to as Medicaid) in Indiana; and

(3) safeguard against overutilization, fraud, abuse, and utilization and provision of services and supplies that are not medically ~~reasonable and~~ necessary.

(b) The purposes for this article are accomplished in this article by means of the following:

(1) A rule describing the ~~prior review and approval~~ **prior authorization** process mandated by IC 12-15-21-3(1).

(2) A rule interpreting the definition of provider as set out in IC 12-7-2-149.

(3) Rules describing the services that require ~~prior review and approval~~ **prior authorization** by the office under IC 12-15-21-3(1).
(4) Rules describing the criteria to be applied by the office in the ~~prior approval~~ **prior authorization** or denial of services under IC 12-15-21-3(1).
(5) Rules describing the limitations consistent with medical necessity on the duration of services to be provided under ~~IC 12-15-21-3(3)(A).~~ **IC 12-15-21-3(3).**
(6) Rules interpreting IC 12-15-5-2 by listing specific services that are not covered by Medicaid because federal financial participation is not available for such services or such services are not medically necessary in view of alternative services available under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-1-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3299; filed Sep 27, 1999, 8:55 a.m.: 23 IR 307; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 83. 405 IAC 5-1-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-1-2 Nondiscrimination

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

Sec. 2. (a) All providers of care and suppliers of services under ~~the Indiana~~ Medicaid ~~program~~ must comply with the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(b) No provider may discriminate in the provision of Medicaid services with regard to age, race, creed, color, national origin, sex, or handicap.

(Office of the Secretary of Family and Social Services; 405 IAC 5-1-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 84. 405 IAC 5-1-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-1-3 Freedom of choice of provider

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-11-2

Sec. 3. Except as provided in 405 IAC 1-1-2(b), all ~~recipients~~ **members** shall have freedom of choice in the selection of a provider of service among qualified providers who meet the requirements of this article and who have executed a provider agreement under IC 12-15-11-2.

(Office of the Secretary of Family and Social Services; 405 IAC 5-1-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 85. 405 IAC 5-1-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-1-4 Solicitation of services

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

Sec. 4. (a) Solicitation, or a fraudulent, misleading, or coercive offer by a provider to provide a service to a ~~Medicaid recipient,~~ **member,** is prohibited. Examples of solicitation include, but are not limited to, the following:
(1) Door-to-door solicitation.
(2) Screenings of large or entire inpatient populations of long term care facilities, hospitals, institutions for

mental diseases, ~~ICFs/MR,~~ **ICFs/IID,** or CRFs/DD, except where such screenings are specifically mandated by law.

(3) The use of any advertisement prohibited by federal or state statute or regulation.

(4) Any other type of inducement or solicitation to cause a ~~recipient~~ **member** to receive a service that the ~~recipient~~ **member** either does not want or does not need.

(b) Solicitation of early and periodic screening, diagnostic, and treatment services, as specified in 405 IAC 5-15, do not violate the solicitation prohibitions in this section.

(Office of the Secretary of Family and Social Services; 405 IAC 5-1-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 86. 405 IAC 5-1-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-1-5 Global fee billing; codes

Authority: 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. 5. (a) Providers must submit one (1) billing for a related group of procedures and services provided to a ~~recipient.~~ **member.**

(b) The Centers for Medicare and Medicaid Service's Common Procedure Coding System (HCPCS) and International Classification of Diseases ~~9th~~ **10th** Revision Clinical Modification ~~(ICD-9-CM)~~ **(ICD-10-CM)** codes shall be used by providers when submitting medical claims to the contractor for adjudication. American Dental Association codes from the Current Dental Terminology Users Manual shall be used by providers when submitting dental claims to the contractor for adjudication. Providers must use the most up-to-date versions of these coding classifications.

(c) Medicaid claims filed by pharmacy providers on the drug claim form/format must utilize an appropriately configured National Drug Code (NDC), Universal Package Code (UPC), Health Related Item Code (HRI), or state-assigned code. When services are billed that have been prior authorized, the procedure code from the prior authorization form shall be utilized. On UB-92 forms, use the appropriate UB-92 Revenue Codes, as well as the narrative descriptions of services, and the appropriate diagnostic and procedure code contained in ~~ICD-9-CM.~~ **ICD-10-CM.**

(d) Documentation in the medical records maintained by the provider must substantiate the medical necessity for the procedure or service and the code selected or description given by the provider. This is subject to postpayment audit and review.

(Office of the Secretary of Family and Social Services; 405 IAC 5-1-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2131; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 87. 405 IAC 5-1-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-1-6 New or experimental product, service, or technology

Authority: 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. 6. (a) A provider may request consideration for coverage of any new or experimental product, service, or technology not specifically covered in this article. Such a request must be submitted by the provider to the ~~fiscal contractor~~ **office** along with a detailed written statement, along with all available supporting documentation, justifying the medical necessity of such product, service, or technology.

(b) This section does not apply to legend drugs.

(Office of the Secretary of Family and Social Services; 405 IAC 5-1-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 88. 405 IAC 5-2-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-3 "Attending provider" defined

Authority: 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. 3. "Attending ~~or primary physician"~~ **provider"** means the ~~physician~~ **provider** who is providing specialized or general medical care to the Medicaid ~~recipient.~~ **member.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 89. 405 IAC 5-2-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-6 "Covered service" defined

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

Sec. 6. "Covered service" means a service **or supply** provided by a ~~Medicaid~~ provider for a ~~Medicaid recipient~~ **member** for which payment is available under ~~the Indiana~~ Medicaid ~~program~~ subject to the limitations of this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 90. 405 IAC 5-2-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-9 "Emergency service" defined

Authority: 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. 9. "Emergency service" means a service provided to a ~~Medicaid recipient~~ **member** after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 91. 405 IAC 5-2-10.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-2-10.5 "HCPCS" defined

Authority: 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. 10.5. "HCPCS" means Healthcare Common Procedure Coding System as set forth in 45 CFR 162.1002.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-10.5)

SECTION 92. 405 IAC 5-2-11.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-2-11.5 "ICF/IID" defined

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-15

Sec. 11.5. "ICF/IID" or "ICFs/IID" has the meaning set forth in 405 IAC 1-1-1(f).

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-11.5)

SECTION 93. 405 IAC 5-2-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-12 "Inpatient services" defined

Authority: 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. 12. "Inpatient services" means only those services provided to a ~~recipient~~ **member** while the ~~recipient~~ **member** is registered as an inpatient in an acute care or psychiatric hospital.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-12; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 94. 405 IAC 5-2-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-13 "ICD-10-CM" defined

Authority: 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. 13. ~~"ICD-9-CM"~~ **"ICD-10-CM"** means International Classification of Diseases – ~~9th~~ **10th** Revision–Clinical Modification **as set forth in 45 CFR 162.1002.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 95. 405 IAC 5-2-13.2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-13.2 "IEP nursing services" defined

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 13.2. "IEP nursing services" means medically necessary services provided by a registered nurse who is employed by or under contract with a Medicaid participating school corporation for a ~~Medicaid recipient~~ **member** pursuant to his or her IEP.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-13.2; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 96. 405 IAC 5-2-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-15 "Level of care" defined

Authority: 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. 15. "Level of care", in an inpatient hospital setting, means the reimbursement methodology used to pay providers for the services rendered, including ~~DRG,~~ **diagnosis related group,** psychiatric, rehabilitation, and burn.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-15; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 97. 405 IAC 5-2-15.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-2-15.5 "Medicaid" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-7-2-128; IC 12-13-7-3; IC 12-15

Sec. 15.5. "Medicaid" has the meaning set forth in 405 IAC 1-1-1(i).

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-15.5)

SECTION 98. 405 IAC 5-2-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-16 "Medical policy" defined

Authority: 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. 16. "Medical policy" means those parameters for coverage of and reimbursement for services and supplies furnished to ~~recipients~~ **members** that are set out in this article, the provider manual, and provider bulletins.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-16; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; filed Sep 27, 1999, 8:55 a.m.: 23 IR 308; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 99. 405 IAC 5-2-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-17 "Medically necessary service" defined

Authority: 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. 17. "Medically ~~reasonable and~~ necessary service" as used in this title means a covered service (as defined in section 6 of this rule) that is required for the care or well-being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:

(1) be medically ~~reasonable and~~ necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and

(2) not be listed in this title as a noncovered service, or otherwise excluded from coverage.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-17; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 378; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 100. 405 IAC 5-2-17.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-2-17.5 "Member" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-7-2-158; IC 12-13-7-3; IC 12-15

Sec. 17.5. "Member" has the meaning set forth in 405 IAC 1-1-1(j).

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-17.5)

SECTION 101. 405 IAC 5-2-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-18 "Office" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-7-2-134; IC 12-13-7-3; IC 12-15

Sec. 18. "Office" ~~means the office of Medicaid policy and planning of the Indiana family and social services administration, that agency designated as the single state agency responsible for the administration of the Indiana Medicaid program.~~ **has the meaning set forth in 405 IAC 1-1-1(m).**

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-18; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 102. 405 IAC 5-2-19 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-19 "Outpatient services" defined

Authority: 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. 19. "Outpatient services" means those services provided to a ~~recipient~~ **member** who is not registered as an inpatient in an acute care or psychiatric hospital except as specifically referenced in a given section.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-19; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 103. 405 IAC 5-2-20 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-20 "Prior authorization" defined

Authority: 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. 20. "Prior authorization" ~~or "prior approval" or "prior review and authorization" or "prior review and approval"~~ means the procedure for the office's prior review and authorization, modification, or denial of payment for covered ~~medical~~ services ~~and supplies~~ within Medicaid allowable charges based upon ~~medical reasonableness and necessity and other~~ criteria as described in 405 IAC 5-3 **and throughout this title.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-20; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 104. 405 IAC 5-2-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-21 "Provider" defined

Authority: IC 12-15

Affected: IC 12-13-7-3

Sec. 21. "Provider" ~~means an individual, state or local agency, or corporate or business entity that meets the requirements of 405 IAC 5-4.~~ **has the meaning set forth in 405 IAC 1-1-1(p).**

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-21; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 105. 405 IAC 5-2-22 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-22 "Provider agreement" defined

Authority: 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. 22. "Provider agreement" ~~or "provider certification agreement"~~ means a contract **or certification agreement** between a provider and the office setting out the terms and conditions of a provider's participation in ~~the Indiana~~ Medicaid, ~~program~~ which must be signed by such provider prior to ~~the payment of~~ any reimbursement for providing covered services to ~~Medicaid recipients.~~ **members.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-22; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 106. 405 IAC 5-2-24 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-24 "Reimbursement" defined

Authority: 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. 24. "Reimbursement" means such payment made to the provider by the office ~~through the contractor,~~ pursuant to federal and state law, as compensation for providing covered services to ~~Medicaid recipients.~~ **members.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-24; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 107. 405 IAC 5-2-29 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-2-29 "Usual and customary charge" defined

Authority: 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. 29. "Usual and customary charge" has the meaning set forth in 405 IAC 1-1-1(s).

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-29)

SECTION 108. 405 IAC 5-3-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-1 Prior authorization; generally

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 1. (a) Except as provided in section 2 of this rule, prior to providing any Medicaid service that requires

prior authorization, the provider must submit a properly completed Medicaid prior ~~review and~~ authorization request and receive written notice indicating the approval for provision of such service.

(b) It is the responsibility of the provider to submit new requests for prior authorization for ongoing services in a timely manner before the current authorization period expires in order to ensure that services are not interrupted.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 109. 405 IAC 5-3-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-2 Prior authorization by telephone

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 2. (a) Prior authorization for selected services is available by telephone when the request is initiated by a provider authorized to request prior authorization as listed in section 10 of this rule. A ~~Medicaid~~ prior ~~review and~~ authorization request form is not necessary for these selected services. Additional written substantiation and documentation may be required by the office. Notification of approval or denial will be given at the time the telephone call is made for the following services:

(1) Inpatient hospital admission and concurrent review, when required under this rule.

(2) Continuation of emergency treatment for those conditions listed in section 13 of this rule on an inpatient basis originally without prior authorization subject to retrospective medical necessity review.

(b) Prior authorization may be obtained by telephone provided a properly completed prior authorization request form is subsequently submitted for the following services:

(1) Medically ~~reasonable and~~ necessary services or supplies to facilitate discharge from or prevent admission to a general hospital.

(2) Equipment repairs necessary for life support or safe mobility of the patient.

(3) Services when a delay of beginning the services could reasonably be expected to result in a serious deterioration of the patient's medical condition.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; filed Sep 27, 1999, 8:55 a.m.: 23 IR 308; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 110. 405 IAC 5-3-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-5 Written requests for prior authorization; contents

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 5. (a) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. A current plan of treatment and progress notes, as to the necessity, effectiveness, and goals of therapy services, must be submitted with the Medicaid prior ~~review and~~ authorization request and available for audit purposes.

(b) For services requiring a written request for authorization, a properly completed Medicaid prior ~~review and~~ authorization request must be submitted and approved by the contractor prior to the service being rendered.

(c) The following information must be submitted with the written prior authorization request form:

(1) The name, address, age, and Medicaid number of the patient.

(2) The name, address, telephone number, provider number, and signature of the provider. The agency will accept any of the following:

(A) A prior authorization request form bearing the original signature of the provider.
(B) A scanned or faxed copy of an originally signed prior authorization request form described in clause (A).
(C) An original prior authorization request form bearing the provider's signature stamp.
(D) A scanned or faxed copy of a prior authorization request form described in clause (C).
(E) The electronic signature of the provider submitted through the prior authorization electronic management system according to agency policy.

(3) Diagnosis and related information. ~~(ICD-9-CM code).~~
(4) Services or supplies requested with appropriate CPT, HCPCS, or ~~ADA~~ **American Dental Association** code.
(5) Name of suggested provider of services or supplies.
(6) Date of onset of medical problems.
(7) Plan of treatment.
(8) Treatment goals.
(9) Rehabilitation potential (where indicated).
(10) Prognosis (where indicated).
(11) Description of previous services or supplies provided, length of such services, or when supply or modality was last provided.
(12) Statement whether durable medical equipment will be purchased, rented, or repaired and the duration of need.
(13) Statement of any other pertinent clinical information that the provider deems necessary to justify medical necessity.
(14) Additional information may be required as needed for clarification, including, but not limited to, the following:
(A) X-rays.
(B) Photographs.
(C) Other services being received.

(15) Diagnosis code.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3304; filed Sep 27, 1999, 8:55 a.m.: 23 IR 308; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Oct 26, 2015, 9:10 a.m.: 20151125-IR-405150070FRA)

SECTION 111. 405 IAC 5-3-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-6 Telephone requests for prior authorization; contents

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 6. A telephone review shall include the following:
(1) Initiation of phone request by a provider authorized to request prior authorization as listed in section 10 of this rule.
(2) The name, address, age, and Medicaid number of the ~~recipient.~~ **member.**
(3) The name, address, telephone number, and provider number of the provider.
(4) Diagnosis and related information. ~~(ICD-9-CM code).~~
(5) Services or supplies requested (CPT or HCPCS code).
(6) Name of suggested provider of services or supplies.
(7) ~~Recipient~~ **Member** specific clinical information required to establish medical necessity, including the following:
(A) Prior history, including results of diagnostic studies.
(B) Prior treatment.
(C) Rationale for treatment plan.
(D) Comorbid conditions.
(E) Treatment plan.
(F) Progress.
(G) Date of onset of medical conditions.
(8) Additional information may be required as needed for clarification, including, but not limited to, the following:
(A) X-rays.
(B) Photographs.

(C) Other services being received.

(9) For emergency admissions, the following information is required, where applicable:

(A) Type of accident.

(B) Accident date.

(10) Diagnosis code.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3304; filed Sep 27, 1999, 8:55 a.m.: 23 IR 309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 112. 405 IAC 5-3-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-7 Determination of member eligibility

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 7. The provider assumes responsibility for verifying the ~~recipient's~~ **member's** eligibility on the service date.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3304; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 113. 405 IAC 5-3-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-8 Limitations

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 8. (a) Any Medicaid service requiring prior authorization, which is provided without first receiving prior authorization, shall not be reimbursed by Medicaid. Prior authorization will be monitored by concurrent or postpayment review.

(b) Any authorization of a service by the ~~contractor~~ **office** is limited to authorization for payment of Medicaid allowable charges and is not an authorization of the provider's estimated fees.

(c) Notwithstanding any prior authorization by the office, the provision of all services and supplies shall comply with the provider agreement, the appropriate provider manual applicable at the time such services or supplies were provided, all other Medicaid policy documents issued to providers, and any applicable state or federal statute or regulation.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3304; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 114. 405 IAC 5-3-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-9 Prior authorization after services have begun

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 9. Prior authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

(1) Pending or retroactive ~~recipient~~ **member** eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the ~~recipient's~~ **member's** Medicaid card.

(2) Mechanical or administrative delays or errors by the ~~contractor or county~~ office. ~~of family and children.~~

(3) Services rendered outside Indiana by a provider who has not yet received a provider manual.
(4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service.
(5) The provider was unaware that the ~~recipient~~ **member** was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:
(A) The provider's records document that the ~~recipient~~ **member** refused or was physically unable to provide the ~~recipient~~ **member** identification (RID or Medicaid) number.
(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
(C) The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 115. 405 IAC 5-3-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-11 Criteria for prior authorization

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 11. The office's decision to authorize, modify, or deny a given request for prior authorization shall include consideration of the following:
(1) Individual case-by-case review of the completed Medicaid prior ~~review and~~ authorization request form.
(2) The medical and social information provided on the request form or documentation accompanying the request form.
(3) Review of criteria set out in this section for the service requested.
(4) The medical necessity of the requested service as defined in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 378; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 116. 405 IAC 5-3-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-12 Prior authorization; exceptions

Authority: IC 12-15
Affected: IC 12-15-30-1

Sec. 12. Notwithstanding any other provision of this rule, prior ~~review and~~ authorization by the office is not required under the following circumstances:
(1) When a service is provided to a ~~Medicaid recipient~~ **member** as an emergency service, "emergency service" means a service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:
(A) placing the patient's health in serious jeopardy;
(B) serious impairment to bodily functions; or
(C) serious dysfunction of any bodily organ or part.
(2) When a ~~recipient's~~ **member's** physician determines that an inpatient hospital setting is no longer necessary, but that Medicaid covered services should continue after the ~~recipient~~ **member** is discharged from inpatient hospital care, such services may continue for a period not to exceed one hundred twenty (120) hours within thirty (30) calendar days of discharge without prior ~~review and~~ authorization, if the physician has specifically ordered such services in writing upon discharge from the hospital. Services provided under this section are subject to all appropriate limitations set out in this rule. This exemption does not apply to durable medical equipment, neuropsychological and psychological testing, or out-of-state medical services. Prior ~~review and~~ authorization by the office must be obtained for reimbursement beyond the one hundred twenty (120) hours within thirty (30) calendar days of discharge period. Physical, speech, respiratory, and

occupational therapies may continue for a period not to exceed thirty (30) hours, sessions, or visits in thirty (30) calendar days without prior ~~approval~~ **authorization** if the physician has specifically ordered such services in writing upon discharge or transfer from the hospital. Prior ~~review and~~ authorization by the office must be obtained for reimbursement beyond the thirty (30) hours, sessions, or visits in the thirty (30) calendar day period for physical, speech, respiratory, and occupational therapies.

(3) The IEP serves as the prior authorization for IEP nursing services and IEP transportation services when provided by a Medicaid participating school corporation in accordance with 405 IAC 5-22-2 and 405 IAC 5-30-11. No additional prior authorization is required.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-12; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305; filed Sep 27, 1999, 8:55 a.m.: 23 IR 309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 28, 2001, 9:56 a.m.: 25 IR 60; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 117. 405 IAC 5-3-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-13 Services requiring prior authorization

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 13. (a) Medicaid reimbursement is available for the following services with prior authorization:

(1) Reduction mammoplasties.
(2) Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem.
(3) Intersex surgery.
(4) Blepharoplasties for a significant obstructive vision problem.
(5) Sliding mandibular osteotomies for prognathism or micrognathism.
(6) Reconstructive or plastic surgery.
(7) Bone marrow or stem cell transplants.
(8) All organ transplants covered by ~~the~~ Medicaid. ~~program.~~
(9) Home health services.
(10) Maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures.
(11) Temporomandibular joint surgery.
(12) Submucous resection of nasal septum and septoplasty when associated with significant obstruction.
(13) Weight reduction surgery, including gastroplasty and related gastrointestinal surgery.
(14) Any procedure ordinarily rendered on an outpatient basis, when rendered on an inpatient basis.
(15) All dental admissions.
(16) Brand medically necessary drugs.
(17) Psychiatric inpatient admissions, including admissions for substance abuse.
(18) Rehabilitation inpatient admissions.
(19) Orthodontic procedures for members under twenty-one (21) years of age for cases of craniofacial deformity or cleft palate.
(20) Genetic testing for detection of cancer of the breast or breasts or ovaries.
(21) Medicaid rehabilitation option services, except for crisis intervention.
(22) Partial hospitalization, as provided under 405 IAC 5-20-8.
(23) Neuropsychological and psychological testing.
(24) As otherwise specified in this article.

(b) If any of the surgeries listed in this section are performed during a hospital stay for another condition, prior authorization is required for the surgical procedure.

(c) Requests for prior authorization for the surgical procedures in this section will be reviewed for medical necessity on a case-by-case basis in accordance with this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3306; filed Sep 1, 2000, 2:16 p.m.: 24 IR 14; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1613; filed Feb 26, 2004, 3:45 p.m.: 27 IR 2244; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2132; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1903; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 18, 2009, 11:32 a.m.: 20090916-IR-405080192FRA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; filed Jul 19, 2010, 11:24 a.m.: 20100818-IR-405090087FRA; readopted filed Oct

28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 118. 405 IAC 5-3-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-14 Prior authorization decision; time limit

Authority: IC 12-15
Affected: IC 12-15-30-1

Sec. 14. Decisions by the office regarding prior ~~review and~~ authorization will be made as expeditiously as possible considering the circumstances of each request. If no decision is made by the office within seven (7) calendar days of receipt of all documentation specified in sections 5 and 9(1) of this rule, authorization is deemed to be granted within the coverage and limitations specified in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-14; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3306; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jun 16, 2011, 8:50 a.m.: 20110713-IR-405100195FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 119. 405 IAC 5-5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-5-2 Prior authorization requirements for out-of-state services

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

Sec. 2. (a) The services listed in section 1 of this rule require prior authorization except as follows:
(1) Emergency services provided out-of-state are exempt from prior authorization; however, continuation of inpatient treatment and hospitalization is subject to the prior authorization requirements of Indiana.
(2) ~~Recipients~~ **Members** of the adoption assistance program placed outside of Indiana will receive approval for all routine medical and dental care provided out-of-state.
(3) Recipients may obtain services listed in section 1 of this rule in the following designated out-of-state cities subject to the prior authorization requirements for in-state services set out in this article:
(A) Louisville, Kentucky.
(B) Cincinnati, Ohio.
(C) Harrison, Ohio.
(D) Hamilton, Ohio.
(E) Oxford, Ohio.
(F) Sturgis, Michigan.
(G) Watseka, Illinois.
(H) Danville, Illinois.
(I) Owensboro, Kentucky.
(4) Recipients may obtain services in Chicago, Illinois, subject to all of the following conditions:
(A) The recipient's physician determines the service is medically necessary.
(B) Transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient's family.
(C) The service is not available in the immediate area.
(D) The recipient's physician complies with all of the criteria set forth in this article, in accordance with the state plan and 42 CFR 456.3.

(b) Prior authorization will not be approved for the following services outside of Indiana and are not covered outside of Indiana for designated cities listed in subsection (a)(3) through (a)(4):
(1) Nursing facilities, ~~ICFs/MR,~~ **ICFs/IID,** or home health agency services.
(2) Any other type of long term care facility, including facilities directly associated with or part of an acute general hospital.

(c) Prior authorization may be granted for any time period from one (1) day to one (1) year for out-of-state medical services listed in section 1 of this rule if the service meets criteria for medical necessity and any one (1) of the following criteria is also met:

(1) The service is not available in Indiana. However, care provided by out-of-state Veterans Administration and Shrine hospitals is an exception to this requirement.
(2) The ~~recipient~~ **member** has received services from the provider previously.
(3) Transportation to an appropriate Indiana facility would cause undue expense or hardship to the ~~recipient~~ **member** or ~~the~~ Medicaid. ~~program.~~
(4) The out-of-state provider is a regional treatment center or distributor.
(5) The out-of-state provider is significantly less expensive than the Indiana providers, for example, large laboratories versus an individual pathologist.

(Office of the Secretary of Family and Social Services; 405 IAC 5-5-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3308; filed Sep 27, 1999, 8:55 a.m.: 23 IR 309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 120. 405 IAC 5-5-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-5-3 Out-of-state suppliers of medical equipment

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

Sec. 3. In order to be treated as an in-state provider for purposes of ~~the~~ prior authorization ~~rule,~~ any out-of-state supplier of medical equipment must comply with the following:
(1) Maintain an Indiana business office, staffed during regular business hours, with telephone service.
(2) Provide service, maintenance, and replacements for Indiana ~~Medicaid recipients~~ **members** whose equipment has malfunctioned.
(3) Qualify with the Indiana secretary of state as a foreign corporation.

(Office of the Secretary of Family and Social Services; 405 IAC 5-5-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 121. 405 IAC 5-6-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-6-1 Restricted utilization; generally

Authority: 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. 1. Certain ~~Medicaid recipients~~ **members** will have restricted utilization information linked to their Medicaid cards when it has been determined that services must be controlled. Providers or services that the ~~recipient~~ **member** may or may not use can be identified through the automated voice response or eligibility verification system.

(Office of the Secretary of Family and Social Services; 405 IAC 5-6-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 122. 405 IAC 5-6-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-6-2 Exceptions; emergency situations and referrals

Authority: 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. 2. (a) A provider other than the one to whom the ~~recipient~~ **member** is restricted may provide treatment to the ~~recipient~~ **member** without a referral from the authorized provider if the diagnosis is an emergency diagnosis.

(b) A provider other than the one to whom the ~~recipient~~ **member** is restricted may provide services to the ~~recipient~~ **member** if the authorized provider has referred the ~~recipient.~~ **member.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-6-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 123. 405 IAC 5-7-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-7-1 Appeals of prior authorization determinations

Authority: 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. 1. (a) ~~Medicaid recipients~~ **Members** may appeal the denial or modification of prior authorization of any Medicaid covered service under 405 IAC 1.1.

(b) Any provider submitting a request for prior authorization under 405 IAC 5-3, which has been denied either in whole or in part, may appeal the decision under 405 IAC 1.1 after exhausting the administrative remedies provided in this rule.

(c) When there is insufficient information submitted to render a decision, a prior authorization request will be suspended for up to thirty (30) days, and the office ~~or its contractor~~ will request additional information from the provider. Suspension is not a final decision on the merits of the request and is not appealable. If the provider does not submit the additional information requested within thirty (30) days, the request shall be denied. Denial is a final decision and may be appealed pursuant to subsections (a) and (b).

(Office of the Secretary of Family and Social Services; 405 IAC 5-7-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 378; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 124. 405 IAC 5-7-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-7-2 Provider requests for administrative review

Authority: 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. 2. (a) A ~~Medicaid~~ provider entitled to submit prior authorization requests who wishes review of denial or modification of a prior authorization decision must request an administrative review before filing an appeal under 405 IAC 1.1.

(b) An administrative review request must be initiated within seven (7) working days of the receipt of modification or denial by the provider who submitted the prior authorization request. The request must be forwarded in writing to the ~~contractor;~~ **office;** telephonic requests will not be accepted.

(Office of the Secretary of Family and Social Services; 405 IAC 5-7-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 125. 405 IAC 5-7-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-7-3 Conduct of administrative review

Authority: 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. 3. (a) The Medicaid contractor will perform the review.

(b) The review will assess medical information pertinent to the case in question.

(c) The review decision of the Medicaid contractor will be rendered within seven (7) working days of request. The time limit for issuance of a decision does not commence until the provider submits a complete request, including all necessary documentation required by the contractor to render a decision.

(d) The requesting provider and ~~recipient~~ **member** will receive written notification of the decision containing the following:

(1) The determination reached by the Medicaid contractor, and the rationale for the decision.

(2) Provider and ~~recipient~~ **member** appeal rights through the office. ~~of Medicaid policy and planning.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-7-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 126. 405 IAC 5-8-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-8-2 "Consultation" defined

Authority: 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. 2. As used in this rule, "consultation" means the rendering of a medical opinion by a physician for a specific ~~recipient,~~ **member,** regarding evaluation or management of a condition, requested by another physician. It requires the consultant physician to examine the patient, unless the applicable standard of care does not require a physical examination. A confirmatory consultation means a second or third opinion. Reimbursement is available for consultative pathology and radiology services under ~~rules 18 and 27 of this article~~ **405 IAC 5-18 and 405 IAC 5-27,** where the consultant physician does not examine the patient.

(Office of the Secretary of Family and Social Services; 405 IAC 5-8-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 127. 405 IAC 5-8-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-8-3 Restrictions

Authority: 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. 3. (a) A consultation cannot be used for the evaluation of a nonphysician referred or self-referred ~~recipient.~~ **member.**

(b) An office or other outpatient consultation must address a specific condition not previously diagnosed or managed by the consulting physician. If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used by the consulting physician again.

(c) Reimbursement for an initial consultation is limited to one (1) per consultant, per ~~recipient,~~ **member,** per inpatient hospital or nursing facility admission.

(d) Follow-up inpatient consultations may be billed if visits are needed to complete the initial consultation, or if subsequent consultative visits are requested by the attending physician. These consultative visits include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status.

(e) If a ~~recipient~~ **member** is referred for management of a condition or the consulting physician assumes patient management, consultation codes cannot be billed to Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-8-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310;

readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 379; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 128. 405 IAC 5-8-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-8-4 Confirmatory consultations

Authority: 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. 4. (a) A confirmatory consultation is the rendering of a second or third medical opinion, completed by a physician for a specific ~~recipient,~~ **member,** regarding evaluation or management of a condition.

(b) A confirmatory consultation may be billed to ~~the~~ Medicaid ~~program~~ only when it is specifically requested by another physician or the ~~Medicaid contractor.~~ **office.**

(c) A confirmatory consultation to substantiate medical necessity may be required as part of the prior authorization process.

(Office of the Secretary of Family and Social Services; 405 IAC 5-8-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 129. 405 IAC 5-9-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-9-1 Limitations

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 1. Medicaid reimbursement is available for office visits limited to a maximum of thirty (30) per calendar year, per ~~recipient,~~ **member,** per provider without prior authorization and subject to the restrictions in section 2 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-9-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2132; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 5, 2010, 2:10 p.m.: 20101201-IR-405090928FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 130. 405 IAC 5-9-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-9-2 Restrictions

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

Sec. 2. (a) Office visits should be appropriate to the diagnosis and treatment given and properly coded.

(b) New patient office visits are limited to one (1) per ~~recipient,~~ **member,** per provider within the last three (3) years. For purposes of this subsection, "new patient" means one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the last three (3) years.

(c) If a physician uses an emergency room as a substitute for his or her office for nonemergency services, these visits should be billed as an office visit and will be reimbursed as such.

(d) If a surgical procedure is performed during the course of an office visit, it should be considered that the

surgical fee includes the medical visit unless the ~~recipient~~ **member** has never been seen by the provider prior to the surgical procedure, or the determination to perform surgery is made during the evaluation of the patient. If an evaluation of a separate clinical condition is performed on the same day as the surgery, both the evaluation and the surgery may be separately billed.

(Office of the Secretary of Family and Social Services; 405 IAC 5-9-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 131. 405 IAC 5-10-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-10-1 Providers eligible for reimbursement

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-2; IC 12-15-5; IC 12-15-30; IC 25-22.5-1-2

Sec. 1. Anesthesia is a Medicaid covered service only when rendered by the following ~~Medicaid~~ providers:
(1) An Indiana Medicaid enrolled physician other than the operating surgeon or surgeon's assistant.
(2) An Indiana Medicaid enrolled practitioner who has a license that allows him or her to administer anesthesia under Indiana law.
(3) An Indiana Medicaid enrolled certified registered nurse anesthetist who practices within the scope of practice of his or her profession in accordance with IC 25-22.5-1-2(a)(12) and who holds a certificate from either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.
(4) An Indiana Medicaid enrolled anesthesiologist assistant who is in compliance with all applicable requirements of state law, including any licensure requirements the state imposes on nonphysician anesthetists and who is a graduate of an educational program that meets all of the following criteria:
(A) Accredited by the Committee on Allied Health Education and Accreditation.
(B) Based at a medical school.
(C) Is of at least two (2) years in duration and included clinical and theory based anesthesia education.

(Office of the Secretary of Family and Social Services; 405 IAC 5-10-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3311; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 132. 405 IAC 5-10-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-10-3 Reimbursement parameters

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-2; IC 12-15-5; IC 12-15-30; IC 25-22.5-1-2

Sec. 3. (a) Services rendered by an anesthetist shall be reimbursed as follows:
(1) Directly to the CRNA, provided that the CRNA has a provider number based on current state registered nurse licensure and is certified or recertified by the Council on Certification of Nurse Anesthetists at the time services were rendered.
(2) Directly to the AA, provided that the AA has a provider number based upon a current state license.
(3) To an anesthesiologist or a professional corporation employing the anesthetist or anesthesiologist at the time services were rendered.
(4) To a hospital or other health care facility employing the anesthetist or anesthesiologist at the time services were rendered.

(b) When an anesthetic is administered for multiple surgical procedures performed during the same operative session, reimbursement will be predicated on the allowed Medicaid payment for the surgical procedure having the highest anesthesia relative value unit.

(c) Anesthesia services must be billed using the coding system required by the office. Anesthesia services performed during separate operative sessions must be billed separately. Each service must be coded on a separate line in order to allow base value. This does not apply to extra services performed during the same

anesthesia services.

(d) Anesthesia services associated with canceled surgery will not be reimbursed.

(e) Local anesthesia (therapeutic or regional blocks) will be reimbursed as a surgical procedure. Time units or modifying factors associated with local anesthesia are not reimbursable. Reimbursement for local anesthesia (therapeutic or regional blocks) administered by the surgeon in conjunction with a surgical procedure is included in the fee for the surgical procedure.

(f) The following services will be reimbursed as surgical procedures:
(1) Cardiopulmonary resuscitation.
(2) Elective external cardioversion.
(3) Administration of blood or blood components.

(g) If reimbursement for a surgical procedure has been disallowed due to lack of prior ~~approval,~~ **authorization,** reimbursement for the anesthesia service will also be disallowed.

(h) Reimbursement is not available for equipment or supplies provided by either an anesthetist or anesthesiologist. Costs associated with equipment or supplies are the responsibility of the facility in which the anesthesia services are provided.

(i) Reimbursement is available for medical direction of a procedure involving an anesthetist only when the direction is by an anesthesiologist, and only when the anesthesiologist medically directs two (2), three (3), or four (4) concurrent procedures involving qualified anesthetists. Reimbursement is not available for medical direction in cases in which an anesthesiologist is concurrently administering anesthesia and providing medical direction.

(j) For single anesthesia sessions involving both an anesthesiologist and an anesthetist, the procedures performed during the session are considered personally performed by the anesthesiologist unless the ~~Medicaid contractor~~ **office** has received documentation that the involvement of both the anesthesiologist and the anesthetist in the procedure was medically necessary. In cases in which the ~~contractor~~ **office** receives the medical necessity documentation, reimbursement may be made for the services of each practitioner.

(Office of the Secretary of Family and Social Services; 405 IAC 5-10-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3311; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 133. 405 IAC 5-12-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-12-1 Reimbursement

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15; IC 25-10-1-1

Sec. 1. (a) Medicaid reimbursement is available for covered services provided by a licensed chiropractor, enrolled as ~~an Indiana Medicaid~~ **a** provider, when rendered within the scope of the practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-1, subject to the restrictions and limitations as described in the rule.

(b) Reimbursement is not available for any chiropractic services provided outside the scope of IC 25-10-1-1 and 846 IAC 1-1, or for any chiropractic service for which federal financial participation is not available.

(Office of the Secretary of Family and Social Services; 405 IAC 5-12-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 134. 405 IAC 5-12-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-12-2 Office visits

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15; IC 25-10-1-1

Sec. 2. Medicaid reimbursement is available for chiropractic office visits and spinal manipulation treatments or physical medicine treatments, subject to the following restrictions:

(1) Reimbursement is limited to a total of fifty (50) office visits or treatments per ~~recipient~~ **member** per year, which includes a maximum reimbursement of no more than five (5) office visits per ~~recipient~~ **member** per year.

(2) Reimbursement is not available for the following types of extended or comprehensive office visits:

(A) New patient detailed.

(B) New patient comprehensive.

(C) Established patient detailed.

(D) Established patient comprehensive.

(3) New patient office visits are reimbursable only once per provider per lifetime of the ~~recipient.~~ **member.** As used in this section, "new patient" means one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three (3) years.

(Office of the Secretary of Family and Social Services; 405 IAC 5-12-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 1, 2003, 10:45 a.m.: 26 IR 2861; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 135. 405 IAC 5-12-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-12-3 Chiropractic x-ray services

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15; IC 25-10-1-1

Sec. 3. Medicaid reimbursement is available for chiropractic x-ray services, subject to the following restrictions:

(1) Reimbursement is limited to one (1) series of full spine x-rays per ~~recipient~~ **member** per year. Component x-rays of the series are individually reimbursable; however, if components are billed separately, total reimbursement is limited to the allowable amount for the series. Prior authorization is not required.

(2) Reimbursement for localized spine series x-rays, and for x-rays of the joints or extremities, is allowable only when the x-rays are necessitated by a condition-related diagnosis. Prior authorization is not required.

(3) Diagnostic radiological exams of the head and vascular system, as defined by the applicable procedure code, are not reimbursable.

(4) Diagnostic ultrasound exams, as defined by the applicable procedure code, are not reimbursable.

(5) X-rays that may be necessitated by the failure of another practitioner to forward, upon request, x-rays or related documentation to a chiropractic provider, are not reimbursable. Chiropractors are entitled to receive x-rays from other providers at no charge to the ~~recipient~~ **member** upon a ~~recipient's~~ **member's** written request to the other providers and upon reasonable notice.

(Office of the Secretary of Family and Social Services; 405 IAC 5-12-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 1, 2003, 10:45 a.m.: 26 IR 2861; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 136. 405 IAC 5-13-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-13-1 Policy; definitions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-32

Sec. 1. (a) Medicaid reimbursement is available for services provided by a certified intermediate care facility for ~~the mentally retarded (ICF/MR)~~ **individuals with intellectual disabilities (ICF/IID)** when such services have been rendered to a ~~Medicaid recipient~~ **member** whose reimbursement has been approved by the office. Such

services must be provided in accordance with IC 12-15-32, 42 CFR 483.400-480, and this rule.

(b) As used in this rule, "small ~~ICF/MR"~~ **ICF/IID"** means a certified intermediate care facility for ~~the mentally retarded (also known as "CRF/DD", which means a certified community residential facility for the developmentally disabled)~~ **individuals with intellectual disabilities** that:

(1) provides ~~ICF/MR~~ **ICF/IID** services for not less than four (4) and not more than eight (8) developmentally disabled persons in a residential setting; and

(2) meets the federal requirements for an ~~ICF/MR~~ **ICF/IID** group home.

(c) As used in this section, "large private ~~ICF/MR"~~ **ICF/IID"** means an institution certified as an intermediate care facility for ~~the mentally retarded~~ **individuals with intellectual disabilities** that:

(1) is not owned ~~and/or~~ **or** operated, **or both,** by an agency of federal, state, or local government; and

(2) serves more than eight (8) developmentally disabled persons.

(d) As used in this rule, "large state ~~ICF/MR"~~ **ICF/IID"** means a state owned or operated facility that provides ~~ICF/MR~~ **ICF/IID** services for more than eight (8) developmentally disabled persons in an institutional setting.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 137. 405 IAC 5-13-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-13-2 Reimbursement

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

Sec. 2. (a) Medicaid reimbursement is available for services provided by a state owned ~~ICF/MR~~ **ICF/IID** in accordance with 405 IAC 1-4.

(b) Medicaid reimbursement is available for services provided by a large private or small ~~ICF/MR~~ **ICF/IID** in accordance with 405 IAC 1-12.

(c) The ~~ICF/MR~~ **ICF/IID** per diem rate covers those services and products furnished by the facility for the usual care and treatment of such patients.

(d) Requests for reimbursement of ~~ICF/MR~~ **ICF/IID** services should be expressed in units of full days. A day begins at midnight and ends twenty-four (24) hours later. The midnight-to-midnight method is to be used when reporting days of service, even if the health facility uses a different definition for statistical or other purposes. The day of discharge is not covered.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 138. 405 IAC 5-13-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-13-3 Services included in the per diem rate for large private and small ICFs/IID

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

Sec. 3. The per diem rate for large private and small ~~ICFs/MR~~ **ICFs/IID** shall include the following services:

(1) Room and board, which includes the following:

(A) Routine and special dietary services.

(B) Personal laundry services.

(C) Room accommodations.

(2) Nursing services and supervision of health services.
(3) Habilitation services provided in a ~~family and social services administration approved~~ setting **approved by the office** that are required by the resident's program plan of active treatment developed in accordance with 42 CFR 483.440, including, but not limited to, the following:
(A) Training in activities of daily living.
(B) Training in the development of self-help and social skills.
(C) Development of program and evaluation plans.
(D) Development and execution of activity schedules.
(E) Vocational/habilitation services.
(4) All medical and nonmedical supplies and equipment furnished by the facility for the usual care and treatment of residents are covered in the per diem rate and may not be billed separately to Medicaid by the facility or by a pharmacy or other provider.
(5) Physical and occupational therapy, speech pathology, and audiology services provided by a licensed, registered, or certified therapist, as applicable, employed by the facility or under contract with the facility are included in the all-inclusive rate. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. All therapies must be specific and effective treatment for the improvement of function. Reimbursement is not available for services for remediation of learning disabilities.
(6) The reasonable cost of necessary transportation for the ~~recipient~~ **member** is included in the per diem rate, including transportation to vocational/habilitation services, except for transportation that is provided to accommodate the delivery of emergency services. Emergency transportation services must be billed to Medicaid directly by the transportation provider.
(7) Durable medical equipment (DME) and associated repair costs, including, but not limited to:
(A) ice bags;
(B) bed rails;
(C) canes;
(D) walkers;
(E) crutches;
(F) standard wheelchairs; or
(G) traction equipment;
are covered in the per diem rate and may not be billed to Medicaid by the facility, a pharmacy, or any other provider. Any other type of nonstandard DME requires prior ~~approval~~ **authorization** by the office and must be billed to ~~the~~ Medicaid ~~program~~ by the DME provider. Facilities shall not require ~~Medicaid recipients~~ **members** to purchase or rent DME with their personal funds. DME purchased with Medicaid funds becomes the property of the office. The facility must notify the ~~county office of family and children~~ **office** when the ~~recipient~~ **member** no longer needs the equipment.
(8) Mental health services provided by the ~~ICF/MR~~ **ICF/IID** are included in the all-inclusive residential per diem rate. These services include the following:
(A) Behavior management services and consulting.
(B) Psychiatric services.
(C) Psychological services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3316; filed Sep 27, 1999, 8:55 a.m.: 23 IR 310; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 139. 405 IAC 5-13-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-13-6 Reserving beds

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

Sec. 6. (a) Medicaid reimbursement is available for reserving beds in an ~~ICF/MR~~ **ICF/IID** for ~~Medicaid recipients,~~ **members,** at one-half (1/2) the regular per diem rate, when one (1) of the following conditions is present:
(1) Hospitalization must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total length of time allowed for payment of a reserved bed for a single hospital stay shall be fifteen (15) days. If the ~~recipient~~ **member** requires hospitalization longer than the fifteen (15) consecutive days, the ~~recipient~~ **member** must be discharged from the facility. If the ~~recipient~~ **member** is discharged from the ~~ICF/MR~~ **ICF/IID** following a hospitalization in excess of fifteen (15) consecutive days, the ~~ICF/MR~~ **ICF/IID** is

still responsible for appropriate discharge planning if the ~~ICF/MR~~ **ICF/IID** does not intend to provide ongoing services following the hospitalization for those individuals who continue to require ~~ICF/MR~~ **ICF/IID** level of services. A physician's order for hospitalization must be maintained in the ~~recipient's~~ **member's** file at the facility.

(2) A leave of absence must be for therapeutic reasons, as prescribed by the attending ~~physician~~ **provider** and as indicated in the ~~recipients~~ **member's** habilitation plan. The total length of time allotted for therapeutic leaves in any calendar year shall be sixty (60) days per ~~recipient~~ **member** residing in an ~~ICF/MR.~~ **ICF/IID.** The leave days need not be consecutive. If the ~~recipient~~ **member** is absent for more than sixty (60) days per year, no further Medicaid reimbursement shall be available for reserving a bed for that ~~recipient~~ **member** in that year. A physician's order for the therapeutic leave must be maintained in the ~~recipient's~~ **member's** file at the facility.

(b) Although prior authorization is not required to reserve a bed, a physician's order for the hospitalization or leave must be maintained in the ~~recipient's~~ **member's** file at the ~~ICF/MR~~ **ICF/IID** to obtain reimbursement at the reserved rate.

(c) If readmission is required, guidelines should be followed as outlined in admission procedures in sections 7 and 8 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3317; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 140. 405 IAC 5-13-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-13-7 Admission and placement; large private and small ICFs/IID

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

Sec. 7. (a) Admissions to large private and small ~~ICFs/MR~~ **ICFs/IID** shall be based upon a determination of the need for such care by the ~~division of disability, aging, and rehabilitative services/bureau of developmental disabilities services.~~ **office.** The interdisciplinary professional team from the proposed placement facility shall review a comprehensive evaluation covering physical, emotional, social, and cognitive factors, as required by federal law, to ensure the facility can meet the needs of the ~~recipient.~~ **member.**

(b) The interdisciplinary professional team includes a physician, a certified social worker, and other professionals, one (1) of whom is a qualified ~~mental retardation~~ **intellectual disability** professional.

(c) A qualified ~~mental retardation~~ **intellectual disability** professional is a person as defined in 42 CFR 483.430.

(d) The following guidelines are applicable for admission and readmission of a ~~recipient~~ **member** to a large private or small ~~ICF/MR:~~ **ICF/IID:**

(1) The office must authorize Medicaid payment for each ~~Medicaid recipient~~ **member** in the large private and small ~~ICF/MR.~~ **ICF/IID.** This process must be completed prior to the first Medicaid payment. Determination of appropriate reimbursement is based on the documentation required by this subsection.

(2) Admission to all large private and small ~~ICF/MR~~ **ICF/IID** facilities requires diagnostic evaluation, including social and psychological components.

(3) ~~BDDS or its designee~~ **The ICF/IID** must submit Form 450B, completed by the physician, for each Medicaid applicant or ~~recipient~~ **member** for whom services are required. The need for care and placement during any payment period must be included in the medical evaluation. The payment period will not be approved for any period of time that precedes the date the physician signs the Form 450B certifying the need for ~~ICF/MR~~ **ICF/IID** services.

(4) Both ~~recipient~~ **member** and provider must have been eligible during any period for which Medicaid reimbursement is requested.

(5) A physician must certify the patient's need for ~~ICF/MR~~ **ICF/IID** care at the time of admission. The first recertification must take place within twelve (12) months from the date of admission certification. Subsequent recertifications must occur annually thereafter, or more often, as determined by the interdisciplinary team.

(6) The certification must specify the level of care required by the ~~recipient,~~ **member,** and the recertification must clearly indicate the need for care to continue at this level. The certification must be signed by the physician and dated at the time of signature. Subsequent recertifications must be signed by a physician, a physician assistant, or a nurse practitioner and dated at the time of signature. (A STAMPED SIGNATURE WILL NOT BE ACCEPTED.)
(7) The admission certification and the three (3) latest recertifications must be kept in the ~~recipient's~~ **member's** active medical record. All other recertification must be kept on file in the facility and be available for review purposes.
(8) Pursuant to 42 CFR 483.440(c)(3), the interdisciplinary professional team must, within thirty (30) days after admission, review and update the preadmission evaluation.
(9) The individual program plan must be reviewed at least by the qualified ~~mental retardation~~ **intellectual disability** professional and revised as necessary as required by 42 CFR 483.440(f).
(10) At least annually, the comprehensive functional assessment of each individual must be reviewed by the interdisciplinary team for relevancy and updated as needed in accordance with 42 CFR 483.440(f)(2).

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3318; filed Sep 27, 1999, 8:55 a.m.: 23 IR 312; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 141. 405 IAC 5-13-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-13-8 Admission to large state ICFs/IID

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-5; IC 12-15-30

Sec. 8. Admissions to large state ~~ICFs/MR~~ **ICFs/IID** shall be based upon a determination of the need for such care by the division of disability, aging, and rehabilitative services/bureau of developmental disabilities services. The interdisciplinary professional team from the proposed placement facility, as required by federal law, shall review the comprehensive evaluation covering physical, emotional, social, and cognitive factors to ensure the ~~recipient's~~ **member's** needs are met. The office must authorize the reimbursement of each ~~Medicaid recipient~~ **member** prior to the first Medicaid payment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3318; filed Sep 27, 1999, 8:55 a.m.: 23 IR 312; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 142. 405 IAC 5-13-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-13-10 Transfer to another ICF/IID

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

Sec. 10. (a) A current Form 450B must be submitted for any transfer to another ~~ICF/MR~~ **ICF/IID** facility. If a diagnosis and evaluation was completed within the last year, it must be submitted.

(b) Each facility is a separate provider and is issued an individual provider number. Each facility must use its assigned provider number. Therefore, transfers between facilities must be done in accordance with procedures outlined in this section.

(c) For large state ~~ICFs/MR,~~ **ICFs/IID,** if the recipient is transferred to a noncertified unit, the admission procedure as described in section 8 of this rule must be followed for any readmission to the large state ~~ICF/MR~~ **ICF/IID** in order to determine reimbursement.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 143. 405 IAC 5-14-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-1 Policy

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 1. (a) Medicaid reimbursement is available only for those dental services listed in section 2 of this rule subject to the limitations set out in this rule.

(b) For those ~~recipients~~ **members** twenty-one (21) years of age and over, covered services routinely provided in a dental office will be limited to one thousand dollars ($1,000) per ~~recipient,~~ **member,** per twelve (12) month period. This limit precedes all other limits within this rule. All procedure codes will be included within the limitation. A provider bulletin issued under this subsection shall be effective no earlier than permitted under IC 12-15-13-6.

(c) For those ~~recipients~~ **members** twenty-one (21) years of age and over, all covered services will require prior authorization except the following:
(1) Diagnostic and preventative services.
(2) Direct restorations.
(3) Treatment of lesions.
(4) Periodontal services for the following immuno-compromised individuals:
(A) Transplant patients.
(B) Pregnant women.
(C) Diabetic patients.
(5) Extractions.
(6) Emergency and trauma care.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1546; filed Aug 17, 2007, 3:23 p.m.: 20070912-IR-405060005FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 4:01 p.m.: 20110608-IR-405100795FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 144. 405 IAC 5-14-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-2 Covered services

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

Sec. 2. The following are covered dental services under ~~the Indiana~~ Medicaid: ~~program:~~
(1) Evaluations.
(2) Radiographs.
(3) Prophylaxis.
(4) Topical fluoride for ~~recipients~~ **members** twenty (20) years of age and younger.
(5) Sealant for permanent molars and premolars for ~~recipients~~ **members** twenty (20) years of age and younger.
(6) Amalgam.
(7) Unilateral and bilateral space maintainers for ~~recipients~~ **members** twenty (20) years of age and younger.
(8) Resin anteriors and posteriors.
(9) Recement crowns.
(10) Steel crown primary.
(11) Stainless steel crown permanent.
(12) Therapeutic pulpotomy.
(13) Extractions.
(14) Oral biopsies.
(15) Alveoplasty.
(16) Excision of lesions.
(17) Excision of benign tumor.

(18) Odontogenic cyst removal.
(19) Nonodontogenic cyst removal.
(20) Incise and drain abscess.
(21) Fracture simple stabilize.
(22) Compound fracture of the mandible.
(23) Compound fracture of the maxilla.
(24) Repair of wounds.
(25) Suturing.
(26) Emergency treatment dental pain.
(27) Analgesia for ~~recipients~~ **members** twenty (20) years of age and younger.
(28) Drugs and medicaments.
(29) Periodontal surgery limited to drug-induced periodontal hyperplasia.
(30) Other dental services as medically necessary to treat ~~recipients~~ **members** eligible for the EPSDT program.
(31) Periodontal root planing and scaling.
(32) General anesthesia.
(33) Intravenous (IV) sedation covered only for oral surgical services.
(34) Dentures and partials.
(35) Orthodontic services for ~~recipients~~ **members** twenty (20) years of age and under only.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2862; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 145. 405 IAC 5-14-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-3 Diagnostic services

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

Sec. 3. Medicaid reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs, and emergency treatments, with the following limitations:
(1) Either a full mouth series or panorex is limited to one (1) set per ~~recipient~~ **member** every three (3) years.
(2) Bitewing radiographs are limited to one (1) set per ~~recipient~~ **member** every twelve (12) months. One (1) set of bitewings is defined as either:
(A) four (4) horizontal films; or
(B) seven (7) to eight (8) vertical films.
(3) Intraoral radiographs are limited to one (1) first film and seven (7) additional films, per ~~recipient~~ **member** every twelve (12) months.
(4) Temporomandibular joint arthrograms, other temporomandibular films, tomographic surveys, and cephalometric films are no longer covered in a dental office.
(5) A comprehensive or detailed oral evaluation is limited to one (1) per lifetime, per ~~recipient,~~ **member,** per provider, with an annual limit of two (2) per ~~recipient.~~ **member.**
(6) A periodic or limited oral evaluation is limited to one (1) every six (6) months, per ~~recipient,~~ **member,** any provider.
(7) Mouth gum cultures and sensitivity tests are not covered.
(8) Oral hygiene instructions:
(A) are reimbursed in the Medicaid payment allowance for diagnostic services; and
(B) may not be billed separately to Medicaid.
(9) Payment for the writing of prescriptions:
(A) is included in the reimbursement for diagnostic services; and
(B) may not be billed separately to Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2863; filed Aug 17, 2007, 3:23 p.m.: 20070912-IR-405060005FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 146. 405 IAC 5-14-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-4 Topical fluoride

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

Sec. 4. Reimbursement is available for one (1) topical application of fluoride every six (6) months per ~~recipient~~ **member** only for patients who are twelve (12) months of age or older but who are younger than twenty-one (21) years of age. Topical applications of fluoride are not covered for ~~recipients~~ **members** twenty-one (21) years of age or older. Brush-in fluoride (topical application of fluoride phosphate) is not a covered service.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2863; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 147. 405 IAC 5-14-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-5 Treatment of dental caries

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

Sec. 5. Treatment of dental caries with amalgam, composites, or resin restorations or stainless steel crowns is covered. The use of pit sealants on permanent molars and premolars only is a covered service for ~~recipients~~ **members** under twenty-one (21) years of age. There is a limit of one (1) treatment per tooth, per lifetime. Margination of restorations and occlusal adjustments are not covered.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 148. 405 IAC 5-14-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-6 Prophylaxis

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

Sec. 6. Prophylaxis is a covered service in accordance with the following limitations:
(1) One (1) unit every six (6) months for noninstitutionalized ~~recipients~~ **members** twelve (12) months of age up to their twenty-first birthday.
(2) One (1) unit every twelve (12) months for noninstitutionalized ~~recipients~~ **members** twenty-one (21) years of age and older.
(3) Institutionalized ~~recipients~~ **members** may receive up to one (1) unit every six (6) months.
(4) Prophylaxis is not covered for ~~recipients~~ **members** under twelve (12) months of age.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2863; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 149. 405 IAC 5-14-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-7 Periodontal root planing and scaling

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

Sec. 7. Periodontal root planing and scaling for ~~recipients~~ **members** over three (3) years of age and under

twenty-one (21) years of age, or for institutionalized ~~recipients,~~ **members,** is limited to four (4) units every two (2) years. For noninstitutionalized ~~recipients~~ **members** twenty-one (21) years of age and older, periodontal root planing and scaling is limited to four (4) units per lifetime.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 150. 405 IAC 5-14-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-15 General anesthesia and intravenous sedation

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

Sec. 15. (a) Medicaid reimbursement is available for general anesthesia. General anesthesia for ~~recipients~~ **members** twenty-one (21) years of age and older may only be provided in a hospital (inpatient or outpatient) or ambulatory surgical center and must include documentation of the following in the patient's record to be eligible for reimbursement:

(1) Specific reasons why such services are needed, including specific justification if such services are to be provided on an outpatient basis.

(2) Documentation that the ~~recipient~~ **member** cannot receive necessary dental services unless general anesthesia is administered. For example, a ~~recipient~~ **member** may be unable to cooperate with the dentist due to physical or mental disability.

(b) Medicaid reimbursement is available for intravenous sedation in a dental office when provided for oral surgical services only. Documentation in the patient's record must include specific reasons why such services are needed, if such services are to be provided on an outpatient basis.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-15; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2864; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 151. 405 IAC 5-14-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-18 Hospital admissions for covered dental services or procedures

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

Sec. 18. The medical necessity for admission of a ~~recipient~~ **member** to a hospital for the purpose of performing any elective dental service, or any elective dental service performed on an inpatient basis, must be documented in the patient's record.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-18; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2864; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 152. 405 IAC 5-14-19 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-19 Prior authorization for early and periodic screening, diagnostic, and treatment covered services

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

Sec. 19. Prior authorization must be obtained for services not listed in section 2 of this rule but which are medically necessary to treat ~~recipients~~ **members** eligible for the EPSDT.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-19; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 153. 405 IAC 5-14-20 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-20 Dental services provided in a state owned ICF/IID

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

Sec. 20. Dental services that can be provided in a state owned ~~ICF/MR~~ **ICF/IID** shall be included in the per diem rate and do not require prior authorization. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization according to the following:

(1) Dental services prior authorized by the contractor must be billed to ~~the~~ Medicaid ~~program~~ directly by the outside dental provider.

(2) Prior authorization shall not be given for dental services provided off-site that are included within the per diem rate.

(3) Documentation on the Medicaid dental prior ~~review and~~ authorization request must substantiate:

(A) the medical necessity of the dental service; and

(B) an explanation of why the service cannot be rendered at the facility.

(4) The office will review criteria for prior authorization set forth in this rule for the specific dental service requested.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-20; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 154. 405 IAC 5-14-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-21 Maxillofacial surgery

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

Sec. 21. ~~Medicaid~~ Providers shall be required, based upon the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to diseases and conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed, such as an ambulatory surgical treatment center, a hospital, or a clinic.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-21; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 155. 405 IAC 5-15-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-15-1 Policy

Authority: 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. 1. EPSDT is a federally mandated preventive health care program covered by Medicaid. The purpose of EPSDT is to facilitate the introduction of young ~~Medicaid recipients~~ **members** into a continuing health care system that will detect abnormalities before such abnormalities become chronic or debilitating. EPSDT program services are covered by Medicaid subject to the limitations set forth in this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-15-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 156. 405 IAC 5-15-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-15-2 Initial screening

Authority: 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. 2. An initial screening will be performed by the EPSDT screening provider when referred by the office ~~or its designee~~ or upon the initial request of the ~~recipient~~ **member** for EPSDT services in accordance with the Indiana EPSDT program recommended screening procedures schedule (hereafter referred to as periodicity schedule). A screening or any portion of a screening is not required where medical contraindications are documented.

(Office of the Secretary of Family and Social Services; 405 IAC 5-15-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 157. 405 IAC 5-15-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-15-3 Periodic screening

Authority: 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. 3. (a) Periodic screenings will be provided by the EPSDT screening provider in accordance with the office's EPSDT periodicity schedule as long as the ~~recipient~~ **member** chooses to participate in the EPSDT program, or until the ~~recipient~~ **member** reaches his or her twenty-first birthday.

(b) A periodic screening shall include the following:
(1) A comprehensive health and developmental history, including assessment of both physical and mental health development.
(2) A comprehensive unclothed physical exam.
(3) A nutritional assessment.
(4) A developmental assessment.
(5) Appropriate vision and hearing testing.
(6) Dental screening.
(7) Health education, including anticipatory guidance.
(8) In addition to the required procedures listed in this subsection, the periodic screening shall include administration of or referral for any other test, procedure, or immunization that is medically necessary or clinically indicated.

(Office of the Secretary of Family and Social Services; 405 IAC 5-15-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 158. 405 IAC 5-15-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-15-4 Treatment

Authority: 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. 4. Any treatment found **medically** necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided subject to any prior authorization requirements for the services set out in this article. However, if a service is not covered under the state plan, it is still available to EPSDT eligible ~~recipients~~ **members** subject to prior authorization requirements ~~of 405 IAC 5-4~~ if it is **medically** necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-15-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.:

20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 159. 405 IAC 5-15-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-15-6 Member and provider participation

Authority: 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. 6. (a) Any ~~Medicaid recipient~~ **member** under twenty-one (21) years of age may participate in the EPSDT program. Each ~~recipient~~ **member** will be informed about the program by the office ~~or its designee~~ in accordance with federal regulations. Participation in EPSDT by ~~Medicaid recipients~~ **members** is voluntary.

(b) Individual physicians, physician group practices, hospitals, or physician-directed clinics who are enrolled as ~~Medicaid~~ providers may provide a complete EPSDT screen.

(c) Any enrolled ~~Medicaid~~ provider may provide EPSDT diagnostic and/or treatment services within the scope of his or her practice upon referral from the screening provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-15-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 160. 405 IAC 5-16-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16-1 Providers eligible for reimbursement

Authority: 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. 1. Services provided to a ~~recipient~~ **member** by:
(1) home health agencies;
(2) clinics;
(3) federally qualified health centers;
(4) free-standing surgical centers;
(5) therapy centers;
(6) rehabilitation centers; or
(7) other such facilities;
are covered subject to the limitations set out in this rule and 405 IAC 5-22.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3325; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 161. 405 IAC 5-16-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16-3 Prior authorization for home health agency services; generally

Authority: 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. 3. (a) All home health services require prior authorization by the office, except the following:
(1) Services provided by a registered nurse, licensed practical nurse, or home health aide, which have been ordered in writing by a physician prior to the patient's discharge from a hospital, and that do not exceed one hundred twenty (120) units within thirty (30) calendar days of discharge from a hospital. These services may not continue beyond thirty (30) calendar days unless prior authorization is received.
(2) Any combination of therapy services ordered in writing by a physician prior to the patient's discharge from a hospital and that do not exceed thirty (30) units within thirty (30) calendar days of discharge from a hospital. These services may not continue beyond thirty (30) calendar days unless prior authorization is received.

(b) Prior authorization requests for home health agency services may be submitted by an authorized representative of the home health agency. Written prior authorization forms must contain the information specified in 405 IAC 5-3-5. Telephone requests for the prior authorization of services will be conducted in accordance with 405 IAC 5-3-2 and 405 IAC 5-3-6.

(c) The following information must be submitted with the written prior authorization request form and may also be requested as written documentation to supplement telephone requests for prior authorization:
(1) Copy of the written plan of treatment, signed by the attending physician.
(2) Estimate of the costs for the required services as ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.

(d) Prior authorization will include consideration of the following, if applicable:
(1) Review of the information provided in the ~~written Medicaid~~ prior ~~review and~~ authorization form, or telephone request for prior authorization, and any additional required or requested documentation.
(2) Review of the following factors when determining the appropriate services, units of service, and length of period for prior authorized services for home care ~~recipients:~~ **members:**
(A) Severity of illness and symptoms.
(B) Stability of the condition and symptoms.
(C) Change in medical condition that affect the type or units of service that can be authorized.
(D) Treatment plan, including identified goals.
(E) Intensity of care required to meet needs.
(F) Complexity of needs.
(G) Amount of time required to complete treatment tasks.
(H) Rehabilitation potential.
(I) Whether the services required in the current care plan are consistent with prior care plans.
(J) Need for instructing the ~~recipient~~ **member** on self-care techniques in the home ~~and~~ or need for instructing the caregiver on caring for the ~~recipient~~ **member** in the home, **or both.**
(K) Other caregiving services received by the recipient, including, but not limited to, services provided by Medicare, Medicaid Waiver Programs, CHOICE, vocational rehabilitation, and private insurance programs.
(L) Caregivers available to provide care for the ~~recipient,~~ **member,** including consideration of the following:
(i) Number of caregivers available.
(ii) Whether the caregiver works outside the home.
(iii) Whether the caregiver attends school outside of the home.
(iv) Reasonably predictable or long term physical limitations of the caregiver that ~~limits~~ **limit** the ability of the caregiver to provide care to the ~~recipient.~~ **member.**
(v) Whether the caregiver has additional child care responsibilities.
(vi) How and when the units of service requested will be used to assist the caregiver in meeting the ~~recipient's~~ **member's** medical needs.
(M) Whether the ~~recipient~~ **member** works or attends school outside of the home, including what assistance is required.
(N) Special situations when additional home health units may be authorized on a short term basis, including the following:
(i) Significant deterioration in the condition of the ~~recipient,~~ **member,** particularly if additional units will prevent an inpatient or extended inpatient hospital admission.
(ii) Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:
(AA) illness or injury that requires an inpatient acute care stay;
(BB) chemotherapy or radiation treatments; or
(CC) a broken limb, which would impair the caregiver's ability to lift the ~~recipient.~~ **member.**
(iii) Temporary, but significant, change in the home situation, including, but not limited to:
(AA) a caregiver's call to military duty; or
(BB) temporary unavailability due to employment responsibilities.
(iv) Significant permanent change in the home situation, including, but not limited to, death or divorce with loss of a caregiver. Additional units of service may be authorized to assist in providing a transition.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3325; filed Aug 27, 1999, 10:15 a.m.: 23 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 162. 405 IAC 5-16-3.1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16-3.1 Home health agency services; limitations

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 3.1. (a) In addition to the prior authorization requirements as outlined in section 3 of this rule, services provided by a registered nurse, licensed practical nurse, home health aide, or renal dialysis aide employed by a home health agency must be as follows:

(1) Prescribed or ordered in writing by a physician.
(2) Provided in accordance with a written plan of treatment developed by the attending physician.
(3) Intermittent or part time, except for ventilator-dependent patients who have a developed plan of home health care.
(4) Health-related nursing care. Homemaker, chore services, and sitter/companion service are not covered, except as specified under applicable Medicaid waiver programs.
(5) Medically ~~reasonable and~~ necessary.
(6) Less expensive than any alternate modes of care.

(b) In addition to the prior authorization requirements as outlined in section 3 of this rule, physical therapy, occupational therapy, respiratory therapy, and speech pathology must be as follows:

(1) Provided by an appropriately licensed, certified, or registered therapist employed or contracted by the agency.
(2) Ordered or prescribed in writing by a physician.
(3) Provided in accordance with a written plan of treatment developed cooperatively between the therapist and the attending physician.
(4) Medically necessary. Educational activities, such as the remediation of learning disabilities, are not covered by Medicaid.
(5) Provided in accordance with 405 IAC 5-22.

(c) Nursing services, which do not meet the definition of emergency services, are covered without prior authorization when provided to a ~~recipient~~ **member** for whom home health services have been currently authorized when the attending physician orders a one (1) time home visit due to a change in the patient's medical condition to prevent deterioration of the patient's medical condition, for example, reanchoring a foley catheter, obtaining a laboratory specimen, administering an injection, or assessing a reported change with signs and symptoms of potential for serious deterioration.

(d) In addition to the limitations as outlined in subsection (a) and section 3 of this rule, telehealth services provided by a home health agency are subject to the following requirements:

(1) The ~~recipient~~ **member** must be receiving home health services.
(2) To initially qualify for telehealth services, the ~~recipient~~ **member** must have had two (2) or more of the following events related to one (1) of the conditions listed in subdivision (3) within the previous twelve (12) months:
  (A) Emergency room visits.
  (B) Inpatient hospital stays.
(3) The ~~recipient~~ **member** must have one (1) or more of the following conditions:
  (A) Chronic obstructive pulmonary disease.
  (B) Congestive heart failure.
  (C) Diabetes.

Additional qualifying conditions may be added by the office upon satisfying the notice requirements set forth in IC 12-15-13-6.

(4) An emergency room visit resulting in an inpatient hospital admission does not constitute two (2) separate events for purposes of meeting the requirements of subdivision (2).
(5) In any telehealth encounter, a licensed registered nurse must perform the reading of transmitted health information provided to the ~~recipient~~ **member** in accordance with the written order of the physician.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-3.1; filed Aug 27, 1999, 10:15 a.m.: 23 IR 18; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep

19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)

SECTION 163. 405 IAC 5-16-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16-5 Rural health clinics and federally qualified health clinics; reimbursement

Authority: 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. 5. Medicaid reimbursement is available to rural health clinics (RHCs) and federally qualified health clinics (FQHCs) for services provided by the following providers:

(1) A physician.
(2) A physician assistant.
(3) A nurse practitioner.
(4) A clinical psychologist.
(5) A clinical social worker.

Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those FQHCs that are located in an area that has a shortage of home health agencies as determined by ~~Medicaid.~~ **the office.** Any other ambulatory service included in the Medicaid state plan is considered a covered FQHC service if the FQHC offers such a service. FQHC services are defined the same as the services provided by RHCs.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3326; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 164. 405 IAC 5-16-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16-6 Freestanding clinics and surgical centers; limitations

Authority: 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. 6. Medicaid reimbursement is available to freestanding clinics and surgical centers for services provided to ~~recipients~~ **members** subject to the following limitations:

(1) Prior authorization is required for all services and supplies the charges for which exceed the cost limits or utilization parameters set out in the this article.
(2) Medicaid reimbursement is not available for facility charges if the services provided are such that they ordinarily could have been provided in a physician's office. Such services provided outside a physician's office will be reimbursed at the fee allowed for the same service provided in the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3326; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 165. 405 IAC 5-16.5-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16.5-1 Definitions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-2; IC 16-18-2-36.5; IC 16-21-2; IC 25-23-1-13.1

Sec. 1. (a) The definitions in this section apply throughout this rule.

(b) "Certified nurse midwife" means a person licensed to practice as a nurse midwife under IC 25-23-1-13.1.

(c) "Freestanding birthing center" means a health facility that is:
(1) not a hospital licensed under IC 16-21-2;

(2) where childbirth is planned to occur away from a pregnant woman's residence;
(3) licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services; and
(4) intended for the sole purpose of delivering a normal, uncomplicated, or low-risk pregnancy.

(d) "Freestanding birthing center services" means services furnished to a recipient at a birthing center as defined in IC 16-18-2-36.5 and this rule.

(e) "Low-risk pregnancy" has the meaning set forth in 410 IAC 27-1-15.5.

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

~~(g) "Recipient" means a Medicaid recipient.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-16.5-1; filed Nov 19, 2013, 2:11 p.m.: 20131218-IR-405120004FRA)

SECTION 166. 405 IAC 5-16.5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16.5-2 Policy; scope

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-2

Sec. 2. (a) The purpose of this rule is to establish a reimbursement methodology for services provided by freestanding birthing centers covered by ~~the Indiana~~ Medicaid. ~~program.~~

(b) A provider's continued participation in ~~the~~ Medicaid ~~program~~ and the receipt of payment for services are contingent on the provider's:
(1) maintaining state licensure of the birthing center; and
(2) conforming with:
(A) the provider agreement entered into by the provider and the office; and
(B) this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16.5-2; filed Nov 19, 2013, 2:11 p.m.: 20131218-IR-405120004FRA)

SECTION 167. 405 IAC 5-16.5-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16.5-3 Reimbursement

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-2

Sec. 3. (a) Covered freestanding birthing center services shall be reimbursed in accordance with this section.
(1) Services, including prenatal labor and delivery, that would otherwise be performed in a hospital setting shall be reimbursed to a freestanding birthing center at a flat rate determined by the office.
(2) A labor management fee when the patient is transferred to a hospital before the delivery is completed shall be paid to a freestanding birthing center at a flat rate determined by the office.
(3) The services of physicians and certified nurse midwives shall be reimbursed in accordance with 405 IAC 1-11.5.

(b) Medicaid reimbursement is available to a freestanding birthing center for services provided to ~~recipients~~ **members** subject to the limitations in this rule and 410 IAC 27.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16.5-3; filed Nov 19, 2013, 2:11 p.m.: 20131218-IR-405120004FRA)

SECTION 168. 405 IAC 5-16.5-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-16.5-4 Limitations

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-2

Sec. 4. (a) Services provided in a birthing center shall be limited in the following manner:
(1) A ~~recipient~~ **member** must be considered as having a normal, uncomplicated, or low-risk pregnancy as defined in 410 IAC 27-1-15.5.
(2) A delivery shall be performed by a:
(A) certified nurse midwife; or
(B) physician.
(3) Surgical services are limited to episiotomy and episiotomy repair and shall not include operative obstetrics or cesarean sections.
(4) Labor shall not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor.
(5) Systemic analgesia may be administered. Local anesthesia may be administered for pudendal block and episiotomy repair.
(6) General and conductive anesthesia shall not be administered at a freestanding birthing center.
(7) A birthing center shall not routinely keep a ~~recipient~~ **member** in the facility for in excess of twenty-four (24) hours.

(b) Medicaid reimbursement is not available for birthing center facility services if the services provided are such that the services ordinarily could have been provided in a physician's office. If such services are provided at a freestanding birthing center, the services will be reimbursed at the fee or rate allowed for the same service provided in a physician's office.

(c) Freestanding birthing center services rendered in a ~~recipient's~~ **member's** home are noncovered services.

(Office of the Secretary of Family and Social Services, 405 IAC 5-16.5-4; filed Nov 19, 2013, 2:11 p.m.: 20131218-IR-405120004FRA)

SECTION 169. 405 IAC 5-17-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-17-1 Reimbursement; limitations

Authority: 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. 1. (a) Inpatient and outpatient hospital services are covered when such services are provided or prescribed and documented by a physician and when the services are medically necessary for the diagnosis or treatment of the ~~recipient's~~ **member's** condition, subject to the limitations set out in this article.

(b) Reimbursement shall not be made for any hospital services not covered under the Medicaid program. In addition, if an inpatient procedure requires prior authorization and prior authorization is either not obtained or denied, reimbursement for the inpatient procedure and any associated services, including inpatient days, shall be denied.

(c) Reimbursement is not available for reserving a bed during a therapeutic leave of absence from an acute care hospital.

(d) Reimbursement for inpatient hospital services is available only when it is determined to be medically ~~reasonable and~~ necessary for the services to be performed only in an inpatient hospital setting.

(e) Reimbursement will be denied for any days of the hospital stay during which the inpatient hospitalization is found not to have been medically necessary.

(f) Reimbursement under the level of care methodology described in 405 IAC 1-10.5 will be made for the lesser of:
(1) the number of days actually used; or
(2) the number of days prior authorized by the office.

(g) The ~~recipient's~~ **member's** medical condition, as described and documented in the medical record by the primary or attending physician must justify the intensity of service provided.

(h) All transfers, including interfacility transfers where the transferring or receiving facility or unit is paid according to the level of care methodology as described in 405 IAC 1-10.5 will be subject to retrospective review.

(Office of the Secretary of Family and Social Services; 405 IAC 5-17-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3326; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 170. 405 IAC 5-17-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-17-2 Prior authorization; generally

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 2. (a) Prior authorization is required for all nonemergent inpatient hospital admissions of Medicaid eligible ~~recipients.~~ **members.** Nonemergent inpatient hospital admissions include all elective or planned inpatient hospital admissions and inpatient hospital admissions for which the patient's condition permitted adequate time to schedule the availability of a suitable accommodation. The following are exempt from this requirement:
(1) Inpatient hospital admissions when covered by Medicare.
(2) Routine vaginal and cesarean section deliveries.

(b) Prior authorization is required for all Medicaid covered rehabilitation, burn, and psychiatric inpatient stays that are reimbursed under the level of care methodology described in 405 IAC 1-10.5 as well as substance abuse stays that are reimbursed under the DRG methodology described at 405 IAC 1-10.5.

(c) Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient procedure, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate ~~DRG,~~ **diagnosis related group,** but will be subject to retrospective review for medical necessity.

(d) Criteria for determining the medical necessity for inpatient admission shall include the following:
(1) Technical or medical difficulties during the outpatient procedure as documented in the medical record.
(2) Presence of physical or mental conditions that make prolonged preoperative or postoperative observations by a nurse or skilled medical personnel a necessity.
(3) Performance of another procedure simultaneously, which itself requires hospitalization.
(4) Likelihood of another procedure following the initial procedure, which would require hospitalization.

(e) Days that are not prior authorized under the level of care methodology as required by this rule will not be covered by Medicaid.

(f) In addition to the prior authorization requirements set forth in this section, prior authorization is also required for the procedures listed in 405 IAC 5-3-13.

(Office of the Secretary of Family and Social Services; 405 IAC 5-17-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 3:58 p.m.: 20110608-IR-405100791FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 171. 405 IAC 5-17-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-17-4 Physical rehabilitation services

Authority: 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. 4. (a) Medicaid reimbursement is available for physical rehabilitation services when such services are prior authorized ~~by the contractor~~ subject to this section.

(b) Prior to admission to a physical rehabilitation unit, an assessment of the patient's total rehabilitative potential must be completed and documented in the medical record.

(c) Medicaid reimbursement is available for physical rehabilitation admission based on the following conditions:
(1) The patient is medically stable.
(2) The patient is responsive to verbal or visual stimuli.
(3) The patient has sufficient mental alertness to participate in the program.
(4) The patient's premorbid condition indicates a potential for rehabilitation.
(5) The expectation for improvement is reasonable.
(6) The criteria listed in 405 IAC 5-32 are met.

(Office of the Secretary of Family and Social Services; 405 IAC 5-17-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 172. 405 IAC 5-17-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-17-5 Inpatient detoxification, rehabilitation, and aftercare for chemical dependency

Authority: 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. 5. (a) Medicaid reimbursement is available for inpatient detoxification, rehabilitation, and aftercare for chemical dependency when such services are prior authorized subject to this section.

(b) Admission to a general hospital floor is not indicated unless the medical services are required for life support and cannot be rendered in a substance abuse treatment unit or facility.

(c) Prior authorization for inpatient detoxification, rehabilitation, and aftercare for chemical dependency shall include consideration of the following:
(1) All requests for prior authorization will be reviewed on a case-by-case basis. ~~by the contractor.~~
(2) The treatment, evaluation, and detoxification are based on the stated medical condition.
(3) The need for safe withdrawal from alcohol or other drugs.
(4) A history of recent convulsions or poorly controlled convulsive disorder.
(5) Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting.

(Office of the Secretary of Family and Social Services; 405 IAC 5-17-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 173. 405 IAC 5-18-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-18-4 Nonanatomical laboratory procedures

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

Sec. 4. (a) The interpretation of laboratory procedures that do not require the services of a physician are not reimbursable. Medicaid reimbursement is available for the interpretation of laboratory results that require the expertise of a physician as indicated by current medical practice standards and in accordance with appropriate

CPT codes.

(b) Consultative pathology services are reimbursable if they:
(1) are requested by the ~~patient's~~ **member's** attending physician in writing;
(2) relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the ~~patient;~~ **member;**
(3) result in a written narrative report included in the ~~patient's~~ **member's** medical record; and
(4) require the exercise of medical judgment by the consultant physician.

(Office of the Secretary of Family and Social Services; 405 IAC 5-18-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 174. 405 IAC 5-19-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-1 Medical supplies

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 1. (a) Medical and surgical supplies (medical supplies) are:
(1) disposable items that are not reusable and must be replaced on a frequent basis;
(2) used primarily and customarily to serve a medical purpose;
(3) generally not useful to a person in the absence of an illness or injury; and
(4) covered only for the treatment of a medical condition.
Reimbursement is available for medical supplies subject to the restrictions listed in this section.

(b) Medical supplies include, but are not limited to, the following:
(1) Antiseptics and solutions.
(2) Bandages and dressing supplies.
(3) Gauze pads.
(4) Catheters.
(5) Incontinence supplies.
(6) Irrigation supplies.
(7) Diabetic supplies, including blood glucose monitors.
(8) Ostomy supplies.
(9) Respiratory and tracheotomy supplies.

(c) Covered medical supplies do not include the following:
(1) Drug products, either legend or nonlegend.
(2) Sanitary napkins.
(3) Cosmetics.
(4) Dentifrice items.
(5) Tissue.
(6) Nonostomy deodorizing products, soap, disposable wipes, shampoo, or other items generally used for personal hygiene.

(d) Providers shall bill for medical supplies in accordance with the instructions set forth in the Indiana health coverage programs manual, bulletins, or banner pages.

(e) Incontinence supplies, including underpads, incontinent briefs and liners, diapers, and disposable diapers, are covered only:
(1) in cases of documented necessity, at a rate determined by the office; and
(2) for ~~recipients~~ **members** three (3) years of age or older.

(f) All medical supplies must be ordered in writing by a physician or dentist.

(g) Medical supplies that are included in facility reimbursement, or that are otherwise included as part of reimbursement for a medical or surgical procedure, are not separately reimbursable to any party. All covered medical supplies, whether for routine or nonroutine use, are included in the per diem for nursing facilities, even if the facility does not include the cost of medical supplies in their facility cost reports.

(h) Reimbursement is not available for medical supplies dispensed in quantities greater than a one (1) month supply for each calendar month, except when:
(1) packaged by the manufacturer only in larger quantities; or
(2) the ~~recipient~~ **member** is a Medicare ~~beneficiary~~ **member** and Medicare allows reimbursement for a larger quantity.

(i) Medical supplies shall be for a specific medical purpose, not incidental or general purpose usage.

(j) Reimbursement for medical supplies is equal to the lower of the following:
(1) The provider's submitted charges, not to exceed the provider's usual and customary charges.
(2) The Medicaid allowable fee schedule amount as determined under this section.

(k) The Medicaid allowable fee schedule amount is the Medicaid fee schedule amount in effect on June 30, 2011. If this amount is not available, the Medicaid allowable shall be the amount determined as follows:
(1) The Indiana Medicare fee schedule amount adjusted by a multiplier of eight-tenths (0.8), if available. If this amount is not available, then subdivision (2).
(2) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then subdivision (3).
(3) The manufacturer's suggested retail price adjusted by a multiplier of seventy-five hundredths (0.75). If this amount is not available, then subdivision (4).
(4) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2).

(l) The office may review the statewide fee schedule and adjust it as necessary, subject to ~~subsections~~ **subsection** (k)(1) through (k)(4). Any adjustments shall be made effective no earlier than permitted under IC 12-15-13-6.

(m) Providers must include their usual and customary charge for each medical supply item when submitting claims for reimbursement. Providers shall not use the Medicaid calculated allowable fee schedule amount for their billed charge unless it is less than or equal to the amount charged by the provider to the general public.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; filed Sep 27, 1999, 8:55 a.m.: 23 IR 313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 10, 2003, 11:01 a.m.: 26 IR 1901; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2133; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jul 5, 2011, 1:39 p.m.: 20110803-IR-405110159FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA)

SECTION 175. 405 IAC 5-19-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-2 "Durable medical equipment" or "DME" defined

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

Sec. 2. As used in this rule, "durable medical equipment" or "DME" means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a ~~recipient~~ **member** in the absence of illness or injury. Items including, but not limited to, the following are examples of DME and may be authorized when medically necessary:
(1) Hospital beds.
(2) Wheelchairs.
(3) Iron lungs.
(4) Respirators.
(5) Oxygen tents.
(6) Commodes.

(7) Traction equipment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3329; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 176. 405 IAC 5-19-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-3 Reimbursement parameters for durable medical equipment

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 3. (a) Medicaid reimbursement is available for the rental or purchase of DME subject to the restrictions listed in this rule.

(b) DME and associated repair costs, including, but not limited to:
(1) ice bags;
(2) bed rails;
(3) canes;
(4) walkers;
(5) crutches;
(6) standard wheelchairs;
(7) traction equipment; or
(8) oxygen and equipment and supplies for its delivery;
for the usual care and treatment of ~~recipients~~ **members** in long-term care facilities are reimbursed in the facility's per diem rate and may not be billed to Medicaid by the facility, pharmacy, or other provider. Nonstandard or custom/special equipment and associated repair costs require prior authorization by the office and may be billed separately to Medicaid, when authorized. Facilities cannot require ~~recipients~~ **members** to purchase or rent such equipment with their personal funds.

(c) Reimbursement of DME is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. The Medicaid allowable amount is the Medicaid fee schedule amount in effect on June 30, 2011. If this amount is not available, the Medicaid allowable shall be the amount determined as follows:
(1) The Indiana Medicare fee schedule amount, if available. If this amount is not available, then subdivision (2).
(2) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then subdivision (3).
(3) The manufacturer's suggested retail price adjusted by a multiplier of seventy-five hundredths (0.75). If this amount is not available, then subdivision (4).
(4) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2).

(d) The office may review the statewide fee schedule and adjust it as necessary, subject to subsection (c)(1) through (c)(4). Any adjustment shall be made effective no earlier than permitted under IC 12-15-13-6.

(e) The total payment for the rental period may not exceed the purchase price.

(f) Items identified by the office that require frequent or substantial servicing will be paid on a rental basis only. No purchase payment will be made.

(g) All DME must be ordered in writing by a physician. The written order must be kept on file for audit purposes.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3329; filed Sep 27, 1999, 8:55 a.m.: 23 IR 313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA)

SECTION 177. 405 IAC 5-19-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-4 Repair of purchased durable medical equipment

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

Sec. 4. Medicaid reimbursement is available for the repair of purchased DME, subject to this rule. All repairs of purchased DME require prior authorization by the office. Medicaid will not make payment for repair of equipment that is still under warranty. No payment shall be authorized for repair necessitated by ~~recipient~~ **member** misuse or abuse. Repair of rental equipment is the responsibility of the rental provider. Payment for maintenance charges for properly functioning equipment is not covered by Medicaid. Repair costs for DME included in a long term care facility's per diem rate is also included in the per diem rate.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3329; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 178. 405 IAC 5-19-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-5 Reimbursement for replacement durable medical equipment

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

Sec. 5. Subject to the criteria set forth in section 7 of this rule, Medicaid will pay for replacement of DME items. Notwithstanding such criteria, authorization for large DME, such as nonstandard or custom/special wheelchairs, hospital beds, and lifts, will not be given more than once every five (5) years per ~~recipient~~ **member** unless there is a change in the ~~recipient's~~ **member's** medical needs, documented in writing by the requesting provider, significant enough to warrant a different type of equipment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; filed Sep 27, 1999, 8:55 a.m.: 23 IR 313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 179. 405 IAC 5-19-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-6 Durable medical equipment subject to prior authorization

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

Sec. 6. (a) Prior authorization by the ~~contractor~~ **office** is required for all DME rented or purchased with Medicaid funds, except for the following:

(1) Cervical collars.
(2) Back supportive devices such as corsets.
(3) Hernia trusses.
(4) Oxygen and supplies and equipment for its delivery for nursing facility residents.
(5) Parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters.

(b) Prior authorization is required for oxygen concentrators, except when used for nursing facility residents who have been certified as needing oxygen services by a physician.

(c) All oxygen equipment and supplies, including concentrators and portable liquid oxygen equipment, require prior authorization for ~~recipients~~ **members** in a home setting. The ~~recipient's~~ **member's** need for oxygen must be certified by a physician.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330;

readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 180. 405 IAC 5-19-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-7 Prior authorization criteria

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

Sec. 7. Prior authorization requests for DME shall be reviewed on a case-by-case basis by the ~~contractor,~~ **office,** using all of the following criteria:

(1) The item must be medically ~~reasonable and~~ necessary, as defined at 405 IAC 5-2-17, for the treatment of an illness or injury or to improve the functioning of a body member.

(2) The item must be adequate for the medical need; however, items with unnecessary convenience or luxury features will not be authorized.

(3) The anticipated period of need, plus the cost of the item will be considered in determining whether the item shall be rented or purchased. This decision shall be made by the ~~contractor~~ **office** based on the least expensive option available to meet the ~~recipient's~~ **member's** needs.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 379; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 181. 405 IAC 5-19-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-8 Ownership of durable medical equipment

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

Sec. 8. DME purchased with Medicaid funds becomes the property of the office. ~~of Medicaid policy and planning.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 182. 405 IAC 5-19-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-9 Wheelchairs and similar motorized vehicles

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

Sec. 9. (a) Medicaid reimbursement is available for wheelchairs or similar motorized vehicles, subject to the restrictions listed in this section, and requires prior authorization.

(b) Motorized vehicles are covered only when the ~~recipient~~ **member** is enrolled in a school, sheltered workshop, or work setting, or if the ~~recipient~~ **member** is left alone for significant periods of time. It must be documented that the ~~recipient~~ **member** can safely operate the vehicle and that the ~~recipient~~ **member** does not have the upper extremity function necessary to operate a manual wheelchair.

(c) Requests for wheelchairs or similar motorized vehicles require a completed medical clearance form submitted with the prior authorization request before the requests shall be reviewed.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 183. 405 IAC 5-19-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-12 Home hemodialysis equipment

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

Sec. 12. (a) Medicaid reimbursement is available for home hemodialysis equipment, including plumbing and water conditioner installation.

(b) Payment for removal and reinstallation of equipment due to ~~recipient~~ **member** relocation is limited to moves made necessary by circumstances beyond the ~~recipient's~~ **member's** control.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-12; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 184. 405 IAC 5-19-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-13 Hearing aids; purchase

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 13. Medicaid reimbursement is available for the purchase, repair, or replacement of hearing aids under the following conditions:

(1) Prior authorization is required for the purchase of hearing aids.

(2) When a ~~recipient~~ **member** is to be fitted with a hearing amplification device by either the audiologist or a registered hearing aid specialist, a medical clearance and audiometric test form must be completed and submitted with the prior authorization request form. Professional services associated with the dispensing of a hearing aid must be performed in accordance with the appropriate provisions of 405 IAC 5-22.

(3) Hearing aids purchased by Medicaid become the property of the office.

(4) Hearing aids are not covered for ~~recipients~~ **members** with a unilateral pure tone average (500, 1,000, 2,000, or 3,000 hertz) equal to or less than thirty (30) decibels.

(5) Binaural aids and CROS-type aids will be authorized only when significant, objective benefit to the ~~recipient~~ **member** can be documented.

(6) Medicaid does not reimburse for canal hearing aids.

(7) Medicaid reimbursement of hearing aids is based on the fee schedule amount in effect on June 30, 2011. If this amount is not available, then use clause (A) as follows:

(A) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then use clause (B).

(B) The manufacturer's suggested retail price adjusted by a multiplier of seventy-five hundredths (0.75).

(8) Reimbursement of a hearing aid dispensing fee is also available subject to the following requirements:

(A) Is a one-time dispensing fee.

(B) May be billed only in conjunction with a hearing aid procedure code that has an established fee schedule amount.

(C) Includes all services related to the initial fitting and adjustment of the hearing aid, orientation of the patient, and instructions on the hearing aid.

(9) Reimbursement for binaural hearing aids will be twice the monaural rate.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; filed Sep 27, 1999, 8:55 a.m.: 23 IR 313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA)

SECTION 185. 405 IAC 5-19-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-14 Hearing aids; maintenance and repair

Authority: IC 12-15

Affected: IC 12-13-7-3

Sec. 14. Medicaid reimbursement is available for the maintenance or repair of hearing aids under the following conditions:

(1) Repairs for hearing aids and ear molds do not require prior authorization; however, reimbursement for such repairs shall not be made more often than once every twelve (12) months. Repairs may be prior authorized more frequently for ~~recipients~~ **members** under twenty-one (21) years of age if circumstances are documented justifying need.

(2) Batteries, sound hooks, tubing, and cords do not require prior authorization.

(3) Medicaid payment is not available for repair of hearing aids still under warranty.

(4) Routine servicing of functioning hearing aids is not covered ~~under the~~ **by** Medicaid. ~~program.~~

(5) No payment shall be made for repair or replacement of hearing aids necessitated by ~~recipient~~ **member** misuse or abuse whether intentional or unintentional.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-14; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA)

SECTION 186. 405 IAC 5-19-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-15 Hearing aids; replacement

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 15. Medicaid reimbursement is available for the replacement of hearing aids under the following conditions:

(1) Medicaid reimbursement is available for the replacement of hearing aids subject to section 14 of this rule.

(2) Requests for replacement of hearing aids must:

(A) document a change in the ~~recipient's~~ **member's** hearing status; and

(B) state the purchase date and condition of the current hearing aid.

(3) Hearing aids shall not be replaced prior to five (5) years from the purchase date. Replacements may be prior authorized more frequently for ~~recipients~~ **members** under twenty-one (21) years of age if circumstances are documented justifying medical necessity.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-15; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA)

SECTION 187. 405 IAC 5-19-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-16 Augmentative communication devices

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

Sec. 16. (a) As used in this section, "augmentative communication device" means a device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication, including both electronic and nonelectronic devices.

(b) As used in this section, "communication device" refers to an augmentative communication device.

(c) Medicaid reimbursement is available for a communication device subject to the following:

(1) The device must be ordered in writing by a medical doctor or doctor of osteopathy.

(2) Prior authorization is required for a communication device. Medical necessity documentation must be provided on, or attached to, the prior authorization request form submitted by the requesting practitioner. A

clinical evaluation by a speech pathologist, substantiating the medical necessity for the communication device, must be submitted as part of the prior authorization request.

(d) Authorization of reimbursement for a communication device may be granted only upon satisfaction of all of the following:

(1) Documentation must be presented that substantiates the ~~recipient~~ **member** has demonstrated sufficient mental and physical capabilities to benefit from the use of the system.

(2) Documentation must be presented that substantiates the ~~recipient,~~ **member,** in the absence of a communication device, cannot effectively make himself or herself understood by others in his or her communication environment.

(3) Documentation must be presented that substantiates the ~~recipient's~~ **member's** medical condition is such that at least two (2) years of use of the device by the ~~recipient~~ **member** can reasonably be expected.

(4) Documentation must be presented that:

(A) identifies all communication devices that would meet the ~~recipient's~~ **member's** communication needs, taking into account the physical and cognitive strengths and weaknesses of the ~~recipient~~ **member** and the ~~recipient's~~ **member's** communication environment; and

(B) recommends the least expensive communication device among those in clause (A).

(5) If authorization is requested for a computer or computerized device, the intended use of the computer or computerized device must be compensation for loss or impairment of communication function.

(e) Reimbursement for repair or replacement of a communication device is available in accordance with section 5 of this rule.

(f) Subject to prior authorization, rehabilitation engineering services necessary to mount or make adjustments to a communication device are covered; and speech therapy services as medically necessary to aid the ~~recipient~~ **member** in the effective use of a communication device are covered subject to this rule and 405 IAC 5-22.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-16; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3332; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 188. 405 IAC 5-19-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-17 Pneumatic artificial voicing systems

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

Sec. 17. (a) Medicaid reimbursement is available for a pneumatic artificial voicing system or an artificial larynx, subject to prior authorization. Prior authorization will be granted only upon satisfaction of the following:

(1) Documentation must be presented that substantiates the ~~recipient~~ **member** has demonstrated sufficient mental and physical capabilities to benefit from the use of the system.

(2) Documentation must be presented that substantiates the ~~recipient~~ **member** has demonstrated sufficient articulation and language skills to benefit from the use of the system.

(b) When a pneumatic artificial voicing system or an artificial larynx is provided on an inpatient basis, the attendant costs are considered to be included in the established per diem rate for the hospital or long term care facility and are not to be separately billed to ~~the~~ Medicaid. ~~program.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-17; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3332; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 189. 405 IAC 5-19-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-18 Noncovered durable medical equipment

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

Sec. 18. The following equipment is not covered by Medicaid:
(1) Equipment that basically serves comfort or convenience functions, for example, the following:
(A) Elevators.
(B) Stairway elevators.
(C) Posture chairs, for example, cardiac chair or geri chair.
(D) Portable whirlpool pumps.
(2) Physical fitness equipment, for example, an exercycle.
(3) First aid or precautionary type equipment, for example, the following:
(A) Preset portable oxygen units.
(B) Spare tanks of oxygen.
(4) Self-help devices, for example, reachers or padded cutlery.
(5) Training equipment.
(6) Cosmetic equipment, for example, sun lamps.
(7) Adaptive or special equipment, for example, the following:
(A) Quad controls for automobiles.
(B) Automobile or van wheelchair lifts.
(C) Room air conditioners or filtering devices.
(8) Air fluidized suspension beds, for example, Clinitron.
(9) Corrective features built into a shoe, such as heels, lifts, or wedges, for ~~recipients~~ **members** twenty-one (21) years of age or older.
(10) Supportive foot devices or orthotics for the foot.
(11) Orthopedic shoes except under the following conditions:
(A) When an integral part of a leg brace.
(B) For a ~~recipient~~ **member** with severe diabetic foot disease.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-18; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3332; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 190. 405 IAC 5-20-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-1 Reimbursement limitations

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

Sec. 1. (a) Medicaid reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, general hospitals, psychiatric residential treatment facilities for children under twenty-one (21) years of age, outpatient mental health facilities, and psychologists endorsed as health service providers in psychology subject to the limitations set out in this rule. For purposes of this rule, "psychiatric residential treatment facility" or "PRTF" means a facility that meets the requirements set forth in section 3.1 of this rule.

(b) Reimbursement for inpatient psychiatric services is not available in institutions for mental diseases for a ~~recipient~~ **member** under sixty-five (65) years of age unless the ~~recipient~~ **member** is under twenty-one (21) years of age, or under twenty-two (22) years of age and had begun receiving inpatient psychiatric services immediately before his or her twenty-first birthday.

(c) Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between twenty-two (22) and sixty-five (65) years of age in a certified psychiatric hospital of sixteen (16) beds or less.

(d) Prior authorization is required for all inpatient psychiatric admissions including admissions for substance abuse.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 191. 405 IAC 5-20-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-2 Reserving beds in psychiatric hospitals and psychiatric residential treatment facilities

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

Sec. 2. (a) Medicaid reimbursement is available for reserving beds in a psychiatric hospital (and not in a general acute care hospital) for hospitalization of ~~Medicaid recipients~~ **members** at one-half (1/2) the regular per diem rate when all of the following conditions are present:

(1) Hospitalization is ordered by the physician for treatment of an acute condition that cannot be treated in the facility.

(2) The total length of time allowed for payment of a reserved bed for a single hospital stay is fifteen (15) days. If the ~~recipient~~ **member** requires hospitalization longer than the fifteen (15) consecutive days, the ~~recipient~~ **member** must be discharged from the facility.

(3) A physician's order for the hospitalization must be maintained in the ~~recipient's~~ **member's** file at the facility.

(b) Medicaid reimbursement is available for reserving beds in a psychiatric residential treatment facility for hospitalization of ~~Medicaid recipients~~ **members** under twenty-one (21) years of age at one-half (1/2) the regular per diem rate subject to all of the following conditions:

(1) Hospitalization is ordered by the physician for treatment of an acute condition that cannot be treated in the psychiatric residential treatment facility.

(2) The total length of time allowed for payment of a reserved bed for a single hospital stay is four (4) days. If the ~~recipient~~ **member** requires hospitalization longer than the four (4) consecutive days, the ~~recipient~~ **member** must be discharged from the psychiatric residential treatment facility.

(3) A physician's order for the hospitalization must be maintained in the ~~recipient's~~ **member's** file at the psychiatric residential treatment facility.

(4) In no instance will Medicaid reimburse a psychiatric residential treatment facility for reserving beds for Medicaid ~~recipients~~ **members** when the facility has an occupancy rate of less than ninety percent (90%).

(c) Medicaid reimbursement is available for reserving beds in a psychiatric hospital, but not in a general care hospital, for the therapeutic leaves of absence of ~~Medicaid recipients~~ **members** at one-half (1/2) the regular per diem rate when all of the following conditions are present:

(1) A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the ~~recipient's~~ **member's** habilitation plan.

(2) In a psychiatric hospital, the total length of time allotted for therapeutic leaves in any calendar year shall be sixty (60) days per ~~recipient.~~ **member.** If the ~~recipient~~ **member** is absent from the psychiatric hospital for more than sixty (60) days per year, no further Medicaid reimbursement shall be available for reserving a bed for that ~~recipient~~ **member** in that year.

(3) A physician's order for therapeutic leave must be maintained in the ~~recipient's~~ **member's** file at the facility.

(d) Medicaid reimbursement is available for reserving beds in a psychiatric residential treatment facility for therapeutic leaves of absence of ~~Medicaid recipients~~ **members** under twenty-one (21) years of age at one-half (1/2) the regular per diem rate when all of the following conditions are present:

(1) A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the ~~recipient's~~ **member's** habilitation plan.

(2) A physician's order for therapeutic leave must be maintained in the ~~recipient's~~ **member's** file at the facility.

(3) In a psychiatric residential treatment facility, the total length of time allotted for therapeutic leaves in any calendar year shall be fourteen (14) days per ~~recipient.~~ **member.** If the ~~recipient~~ **member** is absent from the psychiatric residential treatment facility for more than fourteen (14) days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that ~~recipient~~ **member** in that year.

(4) In no instance will Medicaid reimburse a psychiatric residential treatment facility for reserving beds for ~~Medicaid recipients~~ **members** when the facility has an occupancy rate of less than ninety percent (90%).

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 192. 405 IAC 5-20-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-3 Requirements for psychiatric hospitals

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

Sec. 3. Psychiatric hospitals must meet the following conditions in order to be reimbursed for inpatient services:

(1) The facility must be certified and ~~an Indiana Medicaid~~ **a** provider.

(2) The facility must maintain special medical records for psychiatric hospitals as required by 42 CFR 482.61, effective October 1, 1995, (not including secondary Code of Federal Regulations citations therein).

(3) The facility must provide services under the direction of a licensed physician.

(4) The facility must meet federal certification standards for psychiatric hospitals.

(5) The facility must meet utilization review requirements. The overall operation of a utilization review plan of a facility is monitored by the survey personnel of the Indiana state department of health as contracted by the ~~Indiana family and social services administration.~~ **office.** The hospital will be visited by the inspection of care team annually to review medical and treatment records.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 193. 405 IAC 5-20-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-4 Individually developed plan of care

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

Sec. 4. (a) Each Medicaid eligible ~~patient~~ **member** admitted to a psychiatric hospital or psychiatric residential treatment facility must have an individually developed plan of care. In the case of a person between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less or a person sixty-five (65) years of age and over, the plan of care must be developed by the attending or staff physician. For a person under twenty-one (21) years of age, the plan of care must be developed by the physician and interdisciplinary team. In all cases, the plans of care must be developed not later than fourteen (14) days after admission. For a ~~patient~~ **member** who becomes eligible for Medicaid after admission to a facility, the plan of care must be prepared to cover all periods for which Medicaid coverage is claimed and as follows:

(1) The individual plan of care for a ~~recipient~~ **member** between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less and for a ~~recipient~~ **member** sixty-five (65) years of age and over shall set forth treatment objectives and prescribe an integrated program of appropriate therapies, activities, and experiences designed to meet these objectives. The plan shall be based upon a diagnostic evaluation that includes examination of the medical, psychological, social, and behavioral aspects of the ~~patient's~~ **member's** situation. It shall include, at an appropriate time, a postdischarge plan and plan for coordination of inpatient services with partial discharge plans and appropriate related services in the ~~patient's~~ **member's** community to ensure continuity of care when returned to the ~~patient's~~ **member's** family and community upon discharge. The plan of care shall be reviewed and updated at least every ninety (90) days by the ~~patient's~~ **member's** attending or staff physician for determinations that the services provided were and are required on an inpatient basis and for recommendations as to necessary adjustments in the plan as indicated by the ~~patient's~~ **member's** overall adjustment as an inpatient. The quarterly plan of care must be in writing and made a part of the ~~patient's~~ **member's** record.

(2) The individual plan of care for a ~~recipient~~ **member** under twenty-one (21) years of age shall set forth treatment objectives and prescribe an integrated program of appropriate therapies, activities, and experiences designed to meet these objectives. It shall be formulated in consultation with the child and parents, legal guardians, or others to whose care or custody the individual will be released following discharge. The plan shall be based upon a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the patient's situation. It shall include, at an appropriate time, a postdischarge treatment plan and plan for coordination of inpatient services with partial discharge plans and appropriate related services in the patient's community to ensure continuity of care when returned to the patient's family, school, and community upon discharge. Each plan of care must be reviewed and updated at least every thirty (30) days by the interdisciplinary team for determinations that the services provided were and

are required on an inpatient basis and for recommendations as to any necessary adjustments in the plan as indicated by the patient's overall adjustment as an inpatient. The periodic update of the plan of care must be in writing and made a part of the ~~patient's~~ **member's** record. Recertification is required at least every sixty (60) days. Initial evaluative examinations are exempt from prior ~~review and~~ authorization.

(b) The interdisciplinary team required to develop the plan of care for an individual under twenty-one (21) years of age shall include at least one (1) of the persons identified in subdivisions (1) through (3) and one (1) of the persons identified in subdivision (4) as follows:

(1) A board certified or eligible psychiatrist.

(2) A psychologist endorsed as a health service provider in psychology (HSPP) and a physician licensed to practice medicine or osteopathy.

(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist endorsed as an HSPP or a licensed psychologist.

(4) One (1) of the following (deemed to be other professionals qualified to make determinations as to mental health conditions and treatments thereof):

(A) A licensed, clinical social worker, a licensed marital and family therapist, a licensed mental health counselor, or a person holding a master's degree in social work, marital and family therapy, or mental health counseling.

(B) An advanced practice nurse or a registered nurse who has specialized training or one (1) year experience in treating the mentally ill.

(C) An occupational therapist registered with the National Association of Occupational Therapists and who has specialized training or one (1) year of experience in treating the mentally ill.

(D) A psychologist endorsed as an HSPP or a licensed psychologist.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3334; filed Sep 27, 1999, 8:55 a.m.: 23 IR 314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2477; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 194. 405 IAC 5-20-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-5 Certification of need for admission

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

Sec. 5. Medicaid reimbursement is available for services in an inpatient psychiatric facility only when the ~~recipient's~~ **member's** need for admission has been certified. The certification of need must be completed as follows:

(1) By the attending physician or staff physician for a ~~Medicaid recipient~~ **member** between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less and for a ~~Medicaid recipient~~ **member** sixty-five (65) years of age and over.

(2) In accordance with 42 CFR 441.152(a), effective October 1, 1995 (not including secondary Code of Federal Regulations citations therein) and 42 CFR 441.153, effective October 1, 1995 (not including tertiary Code of Federal Regulations citations resulting therefrom) for an individual twenty-one (21) years of age and under.

(3) By telephone precertification review prior to admission for an individual who is a ~~recipient~~ **member** of Medicaid when admitted to the facility as a nonemergency admission, to be followed by a written certification of need within ten (10) working days of admission.

(4) By telephone precertification review within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written certification of need within fourteen (14) working days of admission. If the provider fails to call within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, Medicaid reimbursement shall be denied for the period from admission to the actual date of notification.

(5) In writing within ten (10) working days after receiving notification of an eligibility determination for an individual applying for Medicaid while in the facility and covering the entire period for which Medicaid reimbursement is being sought.

(6) In writing at least every sixty (60) days after admission, or as requested by the office ~~or its designee,~~ to recertify that the ~~patient~~ **member** continues to require inpatient psychiatric hospital services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 195. 405 IAC 5-20-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-8 Outpatient mental health services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 8. Medicaid reimbursement is available for outpatient mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as a health service provider in psychology (HSPP). Outpatient mental health services rendered by a medical doctor, doctor of osteopathy, or HSPP are subject to the following limitations:

(1) Outpatient mental health services rendered by a medical doctor or doctor of osteopathy are subject to the limitations set out in 405 IAC 5-25.

(2) Subject to prior authorization by the office ~~or its designee,~~ Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when the services are provided by one (1) of the following practitioners:

(A) A licensed psychologist.

(B) A licensed independent practice school psychologist.

(C) A licensed clinical social worker.

(D) A licensed marital and family therapist.

(E) A licensed mental health counselor.

(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.

(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

(3) The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:

(A) The physician, psychiatrist, or HSPP is responsible for seeing the ~~recipient~~ **member** during the intake process or reviewing the medical information obtained by the practitioner listed in subdivision (2) within seven (7) days of the intake process. This review by the physician, psychiatrist, or HSPP must be documented in writing.

(B) The physician, psychiatrist, or HSPP must again see the ~~patient~~ **member** or review the medical information and certify medical necessity on the basis of medical information provided by the practitioner listed in subdivision (2) at intervals not to exceed ninety (90) days. This review must be documented in writing.

(4) Medicaid will reimburse partial hospitalization services under the following conditions and subject to prior authorization:

(A) Partial hospitalization programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are ~~measureable~~ **measurable** and medically necessary. Treatment goals must include specific time frames for achievement of goals, and treatment goals must be directly related to the reason for admission.

(B) Partial hospitalization programs must have the ability to reliably contract for safety. ~~Consumers~~ **Members** with clear intent to seriously harm the self or others are not candidates for partial hospitalization services.

(C) Services may be provided for consumers of all ages who are not at imminent risk to harm ~~to~~ self or others. ~~Consumers~~ **Members** who currently reside in a group home or other residential care setting are not eligible for partial hospitalization services. ~~Consumers~~ **Members** must have a diagnosed or suspected behavioral health condition and one (1) of the following:

(i) A short-term deficit in daily functioning.

(ii) An assessment of the ~~consumer~~ **member** indicating a high probability of serious deterioration of the ~~consumer's~~ **member's** general medical or behavioral health.

(D) Program standards shall be as follows:

(i) Services must be ordered and authorized by a psychiatrist.

(ii) Services require prior authorization pursuant to 405 IAC 5-3-13(a).
(iii) A face-to-face evaluation and an assignment of a behavioral health diagnosis must take place within twenty-four (24) hours following admission to the program.
(iv) A psychiatrist must actively participate in the case review and monitoring of care.
(v) Documentation of active oversight and monitoring of progress by a physician, a psychiatrist, or ~~a~~ **an** HSPP must appear in the ~~consumer's~~ **member's** clinical record.
(vi) At least one (1) individual psychotherapy service or group psychotherapy service must be delivered daily.
(vii) For ~~consumers~~ **members** under eighteen (18) years of age, documentation of active psychotherapy must appear in the ~~consumer's~~ **member's** clinical record.
(viii) For ~~consumers~~ **members** under eighteen (18) years of age, a minimum of one (1) family encounter per five (5) business days of episode of care is required.
(ix) Programs must include four (4) to six (6) hours of active treatment per day and be provided at least four (4) days per week.
(x) Programs must not mix ~~consumers~~ **members** receiving partial hospitalization services with ~~consumers~~ **members** receiving outpatient behavioral health services.

(E) Exclusions shall be as follows:
(i) ~~Consumers~~ **Members** at imminent risk of harm to self or others are not eligible for services.
(ii) ~~Consumers~~ **Members** who concurrently reside in a group home or other residential care setting are not eligible for services.
(iii) ~~Consumers~~ **Members** who cannot actively engage in psychotherapy are not eligible for services.
(iv) ~~Consumers~~ **Members** with withdrawal risk or symptoms of a substance-related disorder whose needs cannot be managed at this level of care or who need detoxification services.
(v) ~~Consumers~~ **Members** who by virtue of age or medical condition cannot actively participate in group therapies are not eligible for services.

(5) Medicaid will reimburse for evaluation and group, family, and individual psychotherapy when provided by a psychologist endorsed as an HSPP.
(6) Subject to prior authorization by the office ~~or its designee,~~ Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by one (1) of the following practitioners:
(A) A physician.
(B) An HSPP.
(C) A practitioner listed in subdivision (7).
(7) The following practitioners may only administer neuropsychological and psychological testing under the direct supervision of a physician or HSPP:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A person holding a master's degree in a mental health field and one (1) of the following:
(i) A certified specialist in psychometry (CSP).
(ii) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.
(8) The physician and HSPP are responsible for the interpretation and reporting of the testing performed.
(9) The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one (1) of the practitioners listed in subdivision (7).
(10) Prior authorization is required for mental health services provided in an outpatient or office setting that exceed twenty (20) units per ~~recipient,~~ **member,** per provider, per rolling twelve (12) month period of time, except neuropsychological and psychological testing, which is subject to prior authorization as stated in subdivision (4)(D)(ii).
(11) The following are services that are not reimbursable by ~~the~~ Medicaid: ~~program:~~
(A) Daycare.
(B) Hypnosis.
(C) Biofeedback.
(D) Missed appointments.
(12) All outpatient services rendered must be identified and itemized on the Medicaid claim form. Additionally, the length of time of each therapy session must be indicated on the claim form. The medical record documentation must identify the services and the length of time of each therapy session. This information must be available for audit purposes.
(13) A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must be attached to the prior authorization form and available for audit purposes.
(14) For psychiatric diagnostic interview examinations, Medicaid reimbursement is available for one (1) unit

per ~~recipient,~~ **member,** per provider, per rolling twelve (12) month period of time, except as follows:

(A) A maximum of two (2) units per rolling twelve (12) month period of time per ~~recipient,~~ **member,** per provider, may be reimbursed without prior authorization, when a ~~recipient~~ **member** is separately evaluated by both a physician or HSPP and a midlevel practitioner.

(B) Of the two (2) units allowed without prior authorization, as stated in clause (A), one (1) unit must be provided by the physician or HSPP and one (1) unit must be provided by the midlevel practitioner.

(C) All additional units require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; filed Sep 27, 1999, 8:55 a.m.: 23 IR 315; filed Jun 9, 2000, 9:55 a.m.: 23 IR 2707; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 28, 2001, 9:56 a.m.: 25 IR 61; errata filed Nov 21, 2001, 11:33 p.m.: 25 IR 1184; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; filed Jul 19, 2010, 11:24 a.m.: 20100818-IR-405090087FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 196. 405 IAC 5-21.5-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-1 Definitions

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 1. (a) As used in this rule, "Medicaid rehabilitation option" **or** "MRO" refers to medical or remedial services recommended by a physician or other licensed professional, within the scope of his or her practice, for the maximum reduction of a mental disability and the restoration of a ~~consumer's~~ **member's** best possible functional level.

(b) As used in this rule, "licensed professional" means any of the following persons:
(1) A licensed psychiatrist.
(2) A licensed physician.
(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
(4) A licensed clinical social worker (LCSW).
(5) A licensed mental health counselor (LMHC).
(6) A licensed marriage and family therapist (LMFT).
(7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

(c) As used in this rule, "qualified behavioral health professional" **or** "QBHP" means any of the following persons:

(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined under subsection (b), ~~above,~~ with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
(A) In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana.
(B) In pastoral counseling from an accredited university.
(C) In rehabilitation counseling from an accredited university.

(2) An individual who is under the supervision of a licensed professional, as defined under subsection (b), ~~above,~~ is eligible for and working towards licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
(A) In social work from a university accredited by the Council on Social Work Education.
(B) In psychology from an accredited university.
(C) In mental health counseling from an accredited university.
(D) In marital and family therapy from an accredited university.

(3) A licensed independent practice school psychologist under the supervision of a licensed professional, as defined in subsection (b). ~~above.~~

(4) An authorized health care professional (AHCP), as used in this rule, means any of the following persons:
(A) A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
(B) A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within

the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

(d) As used in this rule, "other behavioral health professional" **or** "OBHP" means any of the following persons:
(1) An individual with an associate or bachelor degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by either a licensed professional, as defined under subsection (b), ~~above,~~ or a QBHP, as defined under subsection (c). ~~above.~~
(2) A licensed addiction counselor, as defined under IC 25-23.6-10.5 supervised by either a licensed professional, as defined under subsection (b), ~~above,~~ or a QBHP, as defined under subsection (c). ~~above.~~

(e) As used in this rule, "approved division of mental health and addiction (DMHA) assessment tool" refers to a state designated, ~~consumer~~ **member**-appropriate instrument for a provider's assessment of ~~consumer~~ **member** functional impairment.

(f) As used in this rule, "clinic option" refers to services defined under 405 IAC 5-20-8.

(g) As used in this rule, "detoxification services" refer to services defined under 440 IAC 9-2-4.

(h) As used in this rule, "level of need" refers to a recommended intensity of behavioral health services, based on a pattern of a ~~consumer's~~ **member's** and family's needs, as assessed using a standardized assessment instrument.

(i) As used in this rule, "rehabilitative" refers to the federal definition of rehabilitative, as defined under 42 CFR 440.130(d).

(j) As used in this rule, "nonprofessional caregiver" refers to an individual who does not receive compensation for providing care or services to a Medicaid ~~consumer.~~ **member.**

(k) As used in this rule, "professional caregiver" refers to an individual who receives payment for providing services to a Medicaid ~~consumer.~~ **member.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-1; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 197. 405 IAC 5-21.5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-2 Reimbursement

Authority: IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-29

Sec. 2. (a) The office ~~of Medicaid policy and planning (OMPP)~~ will reimburse MRO services for ~~consumers~~ **members** who meet specific diagnosis and level of need criteria under the approved DMHA assessment tool. The listing of diagnostic and level of need criteria approved for reimbursement shall be as follows:
(1) Will be listed and published in a provider manual by the ~~OMPP.~~ **office.**
(2) May be updated by the ~~OMPP~~ **office** as needed.

(b) Services are provided:
(1) through a behavioral health service provider that is ~~an~~ enrolled as a ~~Medicaid~~ provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9; these providers may subcontract for services as appropriate; and
(2) by personnel who meet appropriate federal, state, and local regulations for their respective disciplines or are under the supervision or direction of a licensed professional or QBHP.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-2; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 198. 405 IAC 5-21.5-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-3 Behavioral health rehabilitation services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 3. (a) The services reimbursable as behavioral health rehabilitation services are clinical behavioral health services that are provided for ~~consumers~~ **members,** families, or groups of persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Behavioral health rehabilitation services are as follows:

(1) Behavioral health counseling and therapy.
(2) Medication training and support.
(3) Skills training and development.
(4) Behavioral health level of need redetermination.
(5) Crisis intervention.
(6) Child and adolescent intensive resiliency services.
(7) Adult intensive rehabilitative services.
(8) Intensive outpatient alcohol or drug treatment.
(9) Alcohol or drug (substance-related disorder) counseling.
(10) Peer recovery services.
(11) Case management.
(12) Psychiatric assessment and intervention.

(b) Outpatient behavioral health rehabilitation services may include clinical attention in the ~~consumer's~~ **member's** home, workplace, emergency room, or wherever needed.

(c) Outpatient behavioral health rehabilitation services are rehabilitative in nature and must be indicated in an individualized integrated care plan.

(d) Level of need requirements and maximum allowable units:
(1) will be listed and published in a provider manual by the ~~OMPP;~~ **office;** and
(2) may be updated by the ~~OMPP~~ **office** as needed.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-3; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 199. 405 IAC 5-21.5-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-4 Behavioral health counseling and therapy

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 25-23.6-10.5

Sec. 4. (a) The services reimbursable as individual or group behavioral health counseling and therapy consist of a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. The service must be provided at the ~~consumer's~~ **member's** home or at other locations outside the clinic setting **as follows:**

(1) Requirements for individual or group behavioral health counseling and therapy services shall be as follows:
  (A) Services may be provided for ~~consumers~~ **members** of all ages.
  (B) Providers must meet the either of the following qualifications:
    (i) A licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.
    (ii) A QBHP.
(2) Programming standards shall be as follows:
  (A) The service requires face-to-face contact.
  (B) The ~~consumer~~ **member** is the focus of the service.
  (C) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when services are provided in a group setting.

(D) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.
(E) Service goals must be rehabilitative in nature.
(F) When provided in a group setting, services must be provided in an age appropriate setting for a ~~consumer~~ **member** less than eighteen (18) years of age.
(3) Exclusions shall be as follows:
(A) Services provided in a clinic setting and services provided as a part of school-based services are not billable under the MRO program, and must be billed to the clinic option.
(B) Licensed clinical addiction counselors, as defined under IC 25-23.6-10.5, may not provide this service.
(C) If medication management is a component of the service session, then medication training and support may not be billed separately for the same visit by the same provider.

(b) The services reimbursable as family or couple behavioral health counseling and therapy consist of a series of time-limited, structured, and face-to-face sessions, with or without the ~~consumer~~ **member** present, that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with family members or nonprofessional caregivers. The service must be provided at home or other locations outside the clinic setting **as follows:**
(1) Requirements for family or couple behavioral health counseling and therapy services shall be as follows:
(A) Services may be provided for ~~consumers~~ **members** of all ages.
(B) Providers must meet either of the following qualifications:
(i) A licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.
(ii) A QBHP.
(C) Services may be delivered in an individual or group setting.
(2) Programming standards shall be as follows:
(A) The service requires face-to-face contact.
(B) The ~~consumer~~ **member** is the focus of the service.
(C) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when the ~~consumer~~ **member** is not present and when services are provided in a group setting.
(D) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.
(E) Service goals must be rehabilitative in nature.
(F) When provided in a group setting, services must be provided in an age appropriate setting for a ~~consumer~~ **member** less than eighteen (18) years of age.
(3) Exclusions shall be as follows:
(A) Services provided in a clinic setting and service provided as a part of school-based services are not billable under the MRO program, and must be billed to the clinic option.
(B) Licensed clinical addiction counselors, as defined under IC 25-23.6-10.5, may not provide this service.
(C) If medication management is a component of the service session, then medication training and support may not be billed separately for the same visit by the same provider.
(D) Services may not be provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-4; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 200. 405 IAC 5-21.5-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-5 Medication training and support

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 5. (a) The services reimbursable as individual medication training and support involve face-to-face contact with the ~~consumer~~ **member** for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. This service also includes certain related nonface-to-face activities. Requirements for medication training and support services shall be as follows:
(1) Services may be provided for ~~consumers~~ **members** of all ages.
(2) Medication training and support services must be provided within the scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.
(B) An authorized health care professional (AHCP).
(C) A licensed registered nurse (RN).
(D) A licensed practical nurse (LPN).
(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:
(A) Services must be provided face-to-face in an individual setting that includes monitoring self-administration of prescribed medications and monitoring side effects.
(B) When provided in a clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.
(C) When provided in a residential treatment setting, this service may include components of medication management services.
(D) Services may also include the following services that are not required to be provided face-to-face with the ~~consumer.~~ **member:**
(i) Transcribing physician or AHCP medication orders.
(ii) Setting or filling medication boxes.
(iii) Consulting with the attending physician or AHCP regarding medication-related issues.
(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.
(v) Ensuring that the ~~consumer~~ **member** follows through and receives lab work and services pursuant to other clinical orders.
(vi) Follow-up reporting of lab and clinical test results to the ~~consumer~~ **member** and physician.
(E) The ~~consumer~~ **member** is the focus of the service.
(F) Documentation must support how the service benefits the ~~consumer.~~ **member.**
(G) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.
(H) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:
(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.
(B) Coaching and instruction regarding ~~consumer~~ **member** self-administration of medications is not reimbursable under medication training and support.

(b) The services reimbursable as group medication training and support involve face-to-face contact with the ~~consumer~~ **member** for the purpose of providing education and training about medications and medication side effects. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for ~~consumers~~ **members** twelve (12) years of age and older.

(2) Medication training and support services must be within the provider's scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:
(A) A licensed physician.
(B) An authorized health care professional (AHCP).
(C) A licensed registered nurse (RN).
(D) A licensed practical nurse (LPN).
(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:
(A) Services must be provided face-to-face in a group setting that includes education and training on the administration of prescribed medications and side effects, or conducting medication groups or classes.
(B) When provided in the clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.
(C) When provided in a residential treatment setting, this service may include components of medication management services.
(D) Services must be provided in an age appropriate setting for a ~~consumer~~ **member** less than eighteen (18) years of age receiving services.
(E) The ~~consumer~~ **member** is the focus of the service.
(F) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when services are provided in a group setting.
(G) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.
(H) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) Services may not be provided for ~~consumers~~ **members** under the age of twelve (12) years in a group setting.

(B) If clinic option medication management, counseling, or psychotherapy is provided and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.

(C) Coaching and instruction regarding ~~consumer~~ **member** self-administration of medications is not reimbursable under medication training and support.

(D) The following services are excluded:

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that the ~~consumer~~ **member** follows through, and receives lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the ~~consumer~~ **member** and physician.

(c) The services reimbursable as family or couple medication training and support with or without the ~~consumer~~ **member** present may take place with a family member or other nonprofessional caregiver in an individual setting, and involve face-to-face contact for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing and medical assessments. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for ~~consumers~~ **members** of all ages.

(2) Medication training and support services must be provided within the scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.

(B) An authorized health care professional (AHCP).

(C) A licensed registered nurse (RN).

(D) A licensed practical nurse (LPN).

(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in an individual setting with family members or other nonprofessional caregivers on behalf of the ~~consumer.~~ **member.**

(B) When provided in a clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.

(C) When provided in a residential treatment setting, this service may include components of medication management services.

(D) Services may also include the following services that are not required to be provided face-to-face with the ~~consumer:~~ **member:**

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that the ~~consumer~~ **member** follows through and receives lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the ~~consumer~~ **member** and physician.

(E) The ~~consumer~~ **member** is the focus of the service.

(F) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when the ~~consumer~~ **member** is not present.

(G) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.

(H) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.

(B) Coaching and instruction regarding ~~consumer~~ **member** self-administration of medications is not reimbursable under medication training and support.

(C) Services may not be provided to professional caregivers.

(d) The services reimbursable as family or couple medication training and support with or without the

~~consumer~~ **member** present may take place with a family member or other nonprofessional caregiver in a group setting, and involve face-to-face contact for the purpose of providing education and training about medications and medication side effects. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for ~~consumers~~ **members** of all ages.

(2) Medication training and support services must be provided within the provider's scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.

(B) An authorized health care professional (AHCP).

(C) A licensed registered nurse (RN).

(D) A licensed practical nurse (LPN).

(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in a group setting with family members or other nonprofessional caregivers on behalf of a ~~consumer.~~ **member.** Services include education and training on the administration of prescribed medications and side effects, or conducting medication groups or classes.

(B) When provided in a clinic setting, this service may support, but may not duplicate, activities associated with medication management activities available under the clinic option.

(C) When provided in a residential treatment setting, this service may include components of medication management services.

(D) The ~~consumer~~ **member** is the focus of the service.

(E) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when the ~~consumer~~ **member** is not present and when services are provided in a group setting.

(F) Services must result in demonstrated movement towards, or achievement of, the ~~consumer's~~ **member's** treatment goals identified in the individualized integrated care plan.

(G) Service goals must be rehabilitative in nature.

(H) Services must be provided in an age appropriate setting for a ~~consumer~~ **member** less than eighteen (18) years of age.

(4) Exclusions shall be as follows:

(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.

(B) Coaching and instruction regarding ~~consumer~~ **member** self-administration of medications is not reimbursable under medication training and support.

(C) The following services are excluded:

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that ~~consumers~~ **members** follow through and receive lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the ~~consumer~~ **member** and the physician.

(D) Services may not be provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-5; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 201. 405 IAC 5-21.5-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-6 Skills training and development

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 6. (a) The services reimbursable as individual or group skills training and development involve face-to-face contact that results in the development of skills directed toward eliminating psychosocial barriers. The development of skills is provided through structured interventions for attaining goals identified in the individualized integrated care plan and the monitoring of the ~~consumer's~~ **member's** progress in achieving those skills. Requirements for individual or group skills training and development shall be as follows:

(1) Services may be provided for ~~consumers~~ **members** of all ages.

(2) Services may be provided in an individual setting or group setting.

(3) Providers must meet any of the following qualifications:

(A) A licensed professional.
(B) A QBHP.
(C) An OBHP.

(4) Programming standards shall be as follows:
(A) The service requires face-to-face contact with the ~~consumer.~~ **member.**
(B) ~~Consumers~~ **Members** are expected to show a benefit from services, with the understanding that improvement may be incremental.
(C) Services must result in demonstrated movement towards, or achievement of, the ~~consumer's~~ **member's** treatment goals identified in the individualized integrated care plan.
(D) Services are rehabilitative in nature and time limited.
(E) The ~~consumer~~ **member** is the focus of the service.
(F) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when the service is provided in a group setting.
(G) When provided in a group setting, services must be provided in an age appropriate setting for a ~~consumer~~ **member** less than eighteen (18) years of age.

(5) Exclusions shall be as follows:
(A) Services that are habilitative in nature, except for the achievement of developmental milestones for ~~consumers~~ **members** less than eighteen (18) years of age that would have occurred absent an emotional disturbance.
(B) Skill building activities not identified in the individualized integrated care plan.
(C) Job coaching.
(D) Activities purely for recreation or diversion.
(E) Academic tutoring.

(6) Individual and group skills training and development services are not reimbursable if delivered on the same day as child and adolescent intensive rehabilitative services or adult intensive rehabilitative services.

(b) The services reimbursable as family or couple skills training and development with or without the ~~consumer~~ **member** present involve face-to-face contact with family members or nonprofessional caregivers that result in the development of skills for the ~~consumer~~ **member** directed toward eliminating psychosocial barriers. The development of skills is provided through structured interventions for attaining goals identified in the individualized integrated care plan and the monitoring of progress in achieving those skills. Requirements for these services without the ~~consumer~~ **member** present shall be as follows:

(1) Services may be provided for family members or other nonprofessional caregivers supporting a ~~consumer.~~ **member.**

(2) Services may be provided in an individual or group setting.

(3) Providers must meet any of the following qualifications:
(A) A licensed professional.
(B) A QBHP.
(C) An OBHP.

(4) Programming standards shall be as follows:
(A) The services require face-to-face contact with family members or nonprofessional caregivers on behalf of the ~~consumer.~~ **member.**
(B) ~~Consumers~~ **Members** are expected to show benefit from services, with the understanding that improvement may be incremental.
(C) Services must result in demonstrated movement towards, or achievement of, the ~~consumer's~~ **member's** treatment goals identified in the individualized integrated care plan.
(D) Services must be rehabilitative in nature and time limited.
(E) The ~~consumer~~ **member** is the focus of the service.
(F) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when the ~~consumer~~ **member** is not present and when the service is provided in a group setting.
(G) When provided in a group setting, services must be provided in an age appropriate setting for ~~consumers~~ **members** less than eighteen (18) years of age.

(5) Exclusions shall be as follows:
(A) Skills training that is habilitative in nature, except for the achievement of developmental milestones for ~~consumers~~ **members** less than eighteen (18) years of age that would have occurred absent an emotional disturbance.
(B) Skill building activities not identified in the individualized integrated care plan.
(C) Job coaching.
(D) Activities purely for recreation or diversion.
(E) Academic tutoring.

(F) Services may not be provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-6; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 202. 405 IAC 5-21.5-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-7 Behavioral health level of need redetermination

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 7. (a) The services reimbursable as behavioral health level of need redetermination are services associated with the DMHA approved assessment tool required to determine level of need, assign an MRO service package, and make changes to the individualized integrated care plan.

(b) The redetermination requires face-to-face contact with the ~~consumer~~ **member** and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which result in a completed redetermination.

(c) Requirements for behavioral health level of need redetermination services shall be as follows:
(1) Services may be provided for ~~consumers~~ **members** of all ages.
(2) Services must be provided by individuals meeting DMHA training competency standards for the use of the DMHA-approved assessment tool.
(3) The DMHA assessment tool must be completed at least every six (6) months for the purpose of determining the continued need for MRO services.
(4) Reassessment may occur when there is a significant event or change in ~~consumer~~ **member** status.
(5) Exclusions shall be as follows:
(A) MRO redetermination should not be duplicative of assessments available with clinic option services.
(B) This service may not be billed as part of the initial bio-psychosocial assessment when a ~~consumer~~ **member** is entering treatment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-7; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 203. 405 IAC 5-21.5-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-8 Crisis intervention

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 8. (a) The services reimbursable as crisis intervention services are short-term emergency behavioral health services, available twenty-four (24) hours per day, seven (7) days per week.

(b) These services include crisis assessment, planning, and counseling specific to the crisis, intervention at the site of the crisis when clinically appropriate, and pre-hospital assessment.

(c) The goal of crisis services is to resolve the crisis and transition the ~~consumer~~ **member** to routine care through stabilization of the acute crisis and linkage to necessary services. This service may be provided in an emergency room, crisis clinic setting, or in the community.

(d) The requirements for crisis intervention services shall be as follows:
(1) Services may be provided for all Medicaid ~~consumers~~ **members** who are as follows:
(A) At imminent risk of harm to self or others.
(B) Experiencing a new symptom that places the ~~consumer~~ **member** at risk.
(2) Providers must meet any of the following qualifications:
(A) A licensed professional.

(B) A QBHP.
(C) An OBHP.

(e) Program standards shall be as follows:
(1) The consulting physician, AHCP, or HSPP must be accessible twenty-four (24) hours per day, seven (7) days per week.
(2) Services are provided face-to-face with the ~~consumer.~~ **member.**
(3) Services may include contacts with the family and other nonprofessional caretakers to coordinate community service systems. Contacts are not required to be face-to-face and must be in addition to face-to-face contact with the ~~consumer.~~ **member.**
(4) Services should be limited to occasions when a ~~consumer~~ **member** suffers an acute episode despite the provision of other community behavioral health services.
(5) The intervention should be ~~consumer~~ **member**-centered and delivered on an individual basis.
(6) These services are available to any Medicaid eligible individual in crisis, as defined in this section.
(7) Documentation of action to facilitate a face-to-face visit must be made within one (1) hour of the initial contact with the provider for ~~consumers~~ **members** at imminent risk of harm to self or others.
(8) Documentation of action to facilitate a face-to-face visit must be made within four (4) hours of initial contact with the provider for ~~consumers~~ **members** experiencing a new symptom that places the ~~consumer~~ **member** at risk.
(9) Crisis intervention does not require prior authorization.
(10) The individualized integrated care plan must be updated to reflect the crisis intervention for ~~consumers~~ **members** currently active with the provider.
(11) A brief individualized integrated care plan must be developed and certified for ~~consumers~~ **members** new to the provider, with a full individualized integrated care plan developed following the resolution of the crisis.

(f) Exclusions shall be as follows:
(1) Interventions targeted to groups are not billable as crisis intervention.
(2) Time spent in an inpatient setting is not billable as crisis intervention.
(3) Interventions to address an established problem or need documented in the individualized integrated care plan may not be billed under crisis intervention.
(4) Routine intakes provided without an appointment or after traditional hours do not constitute crisis intervention.
(5) Declared disaster crisis activities and services delivered by a disaster crisis team are excluded.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-8; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 204. 405 IAC 5-21.5-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-9 Child and adolescent intensive resiliency services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 9. (a) The services reimbursable as child and adolescent intensive resiliency services (CAIRS) are time-limited, nonresidential services provided to children or adolescents in a clinically supervised setting that provides an integrated system of individual, family, and group interventions based on an individualized integrated care plan.

(b) Services are designed to alleviate emotional or behavioral problems. Services are curriculum-based with goals that include reintegration into age appropriate community settings.

(c) The requirements for CAIRS shall be as follows:
(1) Services may be provided for ~~consumers~~ **members** at least five (5) years of age and less than eighteen
(18) years of age with severe emotional disturbance who:
(A) need structured therapeutic and rehabilitative services;
(B) have significant impairment in day-to-day personal, social, or vocational functioning;
(C) do not require acute stabilization, including inpatient or detoxification services; and
(D) are not at imminent risk of harm to self or others.

(2) Services may be provided to ~~consumers~~ **members** eighteen (18) years of age and older and less than twenty-one (21) years of age with prior authorization.

(d) Services may be provided in a facility provided by a school district.

(e) Providers must meet any of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.

(f) Programming standards shall be as follows:
(1) Services must be authorized by a physician or an HSPP.
(2) Direct services must be supervised by a licensed professional.
(3) Services are provided in close coordination with the educational program provided by a local school district.
(4) Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
(5) ~~Consumer~~ **Member** goals and a transitional plan must be designed to reintegrate the ~~consumer~~ **member** into the school setting.
(6) Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
(7) A weekly review and update of the ~~consumer's~~ **member's** progress is prepared and is documented in the ~~consumer's~~ **member's** clinical record.
(8) Services must be provided in an age appropriate setting for a ~~consumer~~ **member** eighteen (18) years of age and under.
(9) The ~~consumer~~ **member** is the focus of the service.
(10) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when provided in a group setting.
(11) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.
(12) Service goals must be rehabilitative in nature.
(13) Services must be provided in an age appropriate setting for ~~consumers~~ **members** less than eighteen (18) years of age receiving services.

(g) Exclusions from reimbursement shall be as follows:
(1) Services for ~~consumers~~ **members** less than five (5) years of age.
(2) Services without a prior authorization for ~~consumers~~ **members** eighteen (18) years of age and older, but less than twenty-one (21) years of age.
(3) Services that are purely recreational or diversionary in nature or have no therapeutic or programmatic content.
(4) Formal educational or vocational services.
(5) CAIRS will not be reimbursed for a ~~consumer~~ **member** who receives both CAIRS and adult intensive rehabilitative services on the same day.
(6) CAIRS will not be reimbursed for a ~~consumer~~ **member** who receives both CAIRS and individual or group skills training and development on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-9; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 205. 405 IAC 5-21.5-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-10 Adult intensive rehabilitative services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 10. (a) The services reimbursable as adult intensive rehabilitative services (AIRS) are time-limited, nonresidential services provided in a clinically supervised setting to a ~~consumer~~ **member** who requires structured rehabilitative services in order to maintain the ~~consumer~~ **member** on an outpatient basis.

(b) Services are curriculum based and designed to alleviate emotional or behavioral problems with the goals of:
(1) reintegrating the ~~consumer~~ **member** into the community;
(2) increasing social connectedness beyond a clinical setting; or
(3) employment.

(c) The requirements for AIRS shall be as follows:
(1) Services may be provided for ~~consumers~~ **members** who:
(A) are at least eighteen (18) years of age with serious mental illness who need structured therapeutic and rehabilitative services;
(B) have significant impairment in day-to-day personal, social, or vocational functioning;
(C) do not require acute stabilization, including inpatient or detoxification services; and
(D) are not at imminent risk of harm to self or others.
(2) Services may be provided to ~~consumers~~ **members** less than eighteen (18) years of age, but not less than sixteen (16) years of age with prior authorization.

(d) Providers must meet any of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.

(e) Programming standards shall be as follows:
(1) Services must be authorized by a physician or ~~a~~ **an** HSPP.
(2) Direct services must be supervised by a licensed professional.
(3) Clinical oversight must be provided by a licensed physician, who is on-site weekly and is available to program staff when not physically present.
(4) ~~Consumer~~ **Member** goals must be designed to facilitate community integration, employment, and use of natural supports.
(5) Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
(6) A weekly review and update of progress takes place and is documented in the ~~consumer's~~ **member's** clinical record.
(7) Services must be provided in an age appropriate setting for ~~consumers~~ **members** less than eighteen (18) years of age receiving services.
(8) The ~~consumer~~ **member** is the focus of the service.
(9) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when provided in a group setting.
(10) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.
(11) Service goals must be rehabilitative in nature.

(f) Exclusions from reimbursement shall be as follows:
(1) Services that are purely recreational or diversionary in nature or that do not have therapeutic or programmatic content.
(2) Formal educational or vocational services.
(3) AIRS will not be reimbursed for a ~~consumer~~ **member** who receives both AIRS and individual or group skills training and development on the same day.
(4) AIRS will not be reimbursed for a ~~consumer~~ **member** who receives both AIRS and CAIRS on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-10; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 206. 405 IAC 5-21.5-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-11 Intensive alcohol or drug (substance-related disorder) outpatient treatment

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 11. (a) The services reimbursable as intensive alcohol or drug outpatient treatment services are treatment programs that operate at least three (3) hours per day, and at least three (3) days per week, and are based on an individualized integrated care plan.

(b) Services are planned and organized with addiction professionals and clinicians providing multiple treatment service components for the rehabilitation of alcohol and drug abuse or dependence in a group setting.

(c) Requirements for intensive alcohol or drug outpatient treatment shall be as follows:
(1) Services may be provided for ~~consumers~~ **members** of all ages with a substance-related disorder; minimal or manageable medical conditions; minimal or manageable withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the ~~consumer~~ **member** from benefiting from this level of care.
(2) Providers must meet any of the following qualifications:
(A) A licensed professional.
(B) A QBHP.
(C) An OBHP.

(d) Programming standards shall be as follows:
(1) Regularly scheduled sessions within a structured program must be at least three (3) hours per day and at least three (3) days per week.
(2) The program shall include the following components:
(A) Referral to twelve (12) step programs, peer and other community supports.
(B) Education on addiction disorders.
(C) Skills training in communication, anger management, stress management, and relapse prevention.
(D) Individual, group, and family counseling. Counseling must be provided by a licensed professional or QBHP.
(3) An individual who is a licensed professional is responsible for the overall management of the clinical program.
(4) Treatment must be individualized.
(5) Services must be provided in an age appropriate setting for a ~~consumer~~ **member** less than eighteen (18) years of age receiving services.
(6) At least one (1) of the direct service providers must be a licensed addiction counselor or a licensed clinical addiction counselor.
(7) The ~~consumer~~ **member** if the focus of the service.
(8) Documentation must support how the service benefits the ~~consumer,~~ **member,** including when the service is provided in a group setting.
(9) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.
(10) Service goals must be rehabilitative in nature.

(e) Exclusions shall be as follows:
(1) ~~Consumers~~ **Members** with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.
(2) ~~Consumers~~ **Members** at imminent risk of harm to self or others.
(3) Intensive outpatient treatment will not be reimbursed for ~~consumers~~ **members** who receive group addiction counseling or family/couple group addiction counseling on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-11; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 207. 405 IAC 5-21.5-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-12 Alcohol or drug (substance-related disorder) counseling

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 12. (a) The services reimbursable as individual or group alcohol or drug counseling are services where addiction professionals and clinicians provide counseling intervention that work toward goals identified in the individualized integrated care plan. Services are designed to be a less intensive alternative to intensive outpatient

treatment **as follows:**

(1) The requirements for alcohol or drug counseling shall be as follows:

(A) Services may be provided for ~~consumers~~ **members** of all ages with a substance-related disorder and with minimal or manageable medical conditions; minimal withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the ~~consumer~~ **member** from benefiting from this level of care.

(B) Providers must meet any of the following qualifications:

(i) A licensed professional.

(ii) A QBHP.

(C) Programming standards shall be as follows:

(i) The ~~consumer~~ **member** is the focus of the service.

(ii) Documentation must support how the service specifically benefits the ~~consumer,~~ **member,** including when services are provided in a group setting.

(iii) Services must demonstrate progress toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.

(iv) Service goals must be rehabilitative in nature.

(v) Services are intended to be a less intensive alternative to intensive outpatient treatment.

(vi) Services must be provided in an age appropriate setting for a ~~consumer~~ **member** less than eighteen (18) years of age receiving services.

(vii) A licensed professional must supervise the program and approve the content and curriculum of the program.

(viii) Treatment must consist of regularly scheduled services.

(2) Exclusions shall be as follows:

(A) ~~Consumers~~ **Members** with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.

(B) ~~Consumers~~ **Members** at imminent risk of harm to self or others.

(C) Group addiction counseling will not be reimbursed for ~~consumers~~ **members** who receive intensive outpatient treatment on the same day.

(D) Counseling sessions that consist of education only services will not be reimbursed.

(b) The services reimbursable as family or couple alcohol or drug counseling are services where addiction professionals and clinicians provide face-to-face counseling intervention, with or without the ~~consumer~~ **member** present, that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with family members or nonprofessional caregivers. Services are designed to be a less intensive alternative to intensive outpatient treatment. The requirements for alcohol or drug counseling shall be as follows:

(1) Services may be provided for family members or nonprofessional caregivers of ~~consumers~~ **members** of all ages with a substance-related disorder and with minimal or manageable medical conditions; minimal withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the ~~consumer~~ **member** from benefiting from this level of care.

(2) Services may be provided in an individual or group setting.

(3) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(4) Programming standards shall be as follows:

(A) The ~~consumer~~ **member** is the focus of treatment.

(B) Documentation must support how the service specifically benefits the ~~consumer,~~ **member,** including services provided in a group setting or without the ~~consumer~~ **member** present.

(C) Services must demonstrate progress toward or achievement of the ~~consumer's~~ **member's** treatment goals identified in the individualized integrated care plan.

(D) Service goals must be rehabilitative in nature.

(E) Services are intended to be a less intensive alternative to outpatient treatment services.

(F) Services must be provided in an age appropriate setting for a ~~consumer~~ **member** eighteen (18) years of age and under receiving services.

(G) A licensed professional must supervise the program and approve the content and curriculum of the program.

(H) Treatment must consist of regularly scheduled services.

(5) Exclusions shall be as follows:

(A) ~~Consumers~~ **Members** with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.

(B) ~~Consumers~~ **Members** at imminent risk of harm to self or others.

(C) Services may not be provided to professional caregivers.
(D) Counseling sessions that consist of education only services will not be reimbursed.
(E) Family or couple group alcohol or drug counseling will not be reimbursed for ~~consumers~~ **members** who receive intensive outpatient treatment on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-12; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 208. 405 IAC 5-21.5-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-13 Peer recovery services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 13. The services reimbursable as peer recovery services are face-to-face, structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Requirements for peer recovery services shall be as follows:

(1) Services may be provided for ~~consumers~~ **members** eighteen (18) years of age and older. Services may be provided for ~~consumers~~ **members** age sixteen (16) or seventeen (17) with prior authorization. Services shall not be provided to or for a ~~consumer~~ **member** less than sixteen (16) years of age.
(2) Services must be provided by individuals meeting DMHA training and competency standards for certified recovery specialists. Individuals providing peer recovery services must be under the supervision of a licensed professional or a QBHP.
(3) Programming standards shall be as follows:
(A) Services must be identified in the individualized integrated care plan and must correspond to specific treatment goals.
(B) Services must be provided face-to-face and include the following components:
(i) Assisting ~~consumers~~ **members** with developing individualized integrated care plans and other formal mentoring activities aimed at increasing the active participation of ~~consumers~~ **members** in person-centered planning and delivery of individualized services.
(ii) Assisting ~~consumers~~ **members** with the development of psychiatric advanced directives.
(iii) Supporting ~~consumers~~ **members** in problem solving related to reintegration into the community.
(iv) Education and promotion of recovery and anti-stigma activities.
(C) Documentation must support how the service specifically benefits the ~~consumer.~~ **member.**
(D) The ~~consumer~~ **member** is the focus of the treatment.
(E) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.
(F) Service goals must be rehabilitative in nature.
(G) Services must be provided in an age appropriate setting for a ~~consumer~~ **member** eighteen (18) years of age and under receiving services.
(4) Exclusions shall be as follows:
(A) Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed.
(B) Interventions targeted to groups are not billable as peer recovery services.
(C) Activities that may be billed under skills training and development or case management services are not billable under peer recover services.
(D) Services are not reimbursable for ~~consumers~~ **members** less than sixteen (16) years of age.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-13; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 209. 405 IAC 5-21.5-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-14 Case management services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 14. The services reimbursable as case management services are services that help ~~consumers~~ **members** gain access to needed medical, social, educational, and other services. Case management services

include the assessment of the eligible ~~consumer~~ **member** to determine service needs, development of an individualized integrated care plan, referral and related activities to help the ~~consumer~~ **member** obtain needed services, monitoring and follow-up, and evaluation. Case management is a service on behalf of the ~~consumer,~~ **member,** not to the ~~consumer,~~ **member,** and is management of the case, not the ~~consumer.~~ **member.** Requirements for case management services shall be as follows:

(1) Services may be provided for ~~consumers~~ **members** of all ages.

(2) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(C) An OBHP.

(3) Programming standards shall be as follows:

(A) Medicaid case management services must provide direct assistance in gaining access to needed medical, social, educational, and other services.

(B) Case management services include:

(i) development of an individualized integrated care plan;

(ii) limited referrals to services; and

(iii) activities or contacts necessary to ensure that the individualized integrated care plan is effectively implemented and adequately addresses the mental health or addiction needs of the ~~consumer.~~ **member.**

(C) Services specifically may include the following:

(i) Needs assessment focusing on needs identification of the ~~consumer~~ **member** in order to determine the need for any medical, educational, social, or other services.

(ii) Development of an individualized integrated care plan to identify the rehabilitative activities and assistance needed to accomplish the objectives of the plan.

(iii) Referral or linkage to activities that help link the ~~consumer~~ **member** with services that are capable of providing needed rehabilitative services.

(iv) Monitoring or follow-up with the ~~consumer,~~ **member,** family members, nonprofessional caregivers, providers, or other entities, including making necessary adjustments in the individualized integrated care plan and service arrangement with providers.

(v) Evaluation consistent with the needs of the ~~consumer;~~ **member;** time devoted to formal supervision of the case between case manager and licensed supervisor are included activities and should be documented accordingly.

(D) Exclusions shall be as follows:

(i) Activities billed under behavioral health level of need redetermination.

(ii) The actual or direct provision of medical services or medical treatment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-14; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 210. 405 IAC 5-21.5-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-15 Psychiatric assessment and intervention

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 15. The services reimbursable as psychiatric assessment and intervention services are face-to-face and nonface-to-face activities that are designed to provide psychiatric assessment, consultation, and intervention services to ~~consumers.~~ **members.** Requirements for psychiatric assessment and intervention services shall be as follows:

(1) Services may be provided for ~~consumers~~ **members** eighteen (18) years and older with a history of multiple hospitalizations and severe challenges in maintaining independent living within the community. Services may be prior authorized for ~~consumers~~ **members** less than eighteen (18) years of age.

(2) Providers must meet any of the following qualifications:

(A) A physician.

(B) An AHCP.

(3) Programming standards shall be as follows:

(A) Service delivery may include both face-to-face and certain nonface-to-face activities.

(B) Psychiatric assessment services are intensive and must be available twenty-four (24) hours per day, seven (7) days per week, and with emergency response.

(C) Services must include, but are not limited to, the following:

(i) Symptom assessment and intervention to observe, monitor, and care for the physical, nutritional,

behavioral health, and related psychosocial issues, problems, or crises manifested in the course of a ~~consumer's~~ **member's** treatment.

(ii) Monitoring a ~~consumer's~~ **member's** medical and other health issues that are either directly related to a mental health disorder or a substance related disorder, or to the treatment of the disorder.

(iii) Consultation on assessment, service planning, and implementation with other members of the ~~consumer's~~ **member's** treatment team, the ~~consumer's~~ **member's** family, and nonprofessional caregivers.

(D) The ~~consumer~~ **member** is the focus of the service.

(E) Documentation must support how the service benefits the ~~consumer.~~ **member.**

(F) Services must demonstrate movement toward or achievement of ~~consumer~~ **member** treatment goals identified in the individualized integrated care plan.

(G) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) Medication management activities provided in a clinic setting that may be reimbursed under the clinic option.

(B) Services that may be reimbursed under the clinic option.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-15; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 211. 405 IAC 5-21.5-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.5-17 Prior authorization

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 17. (a) MRO services are packaged according to diagnosis and level of need. Diagnosis and level of need qualifications for service packages, and services included within each service package:

(1) will be listed and published in a provider manual by the OMPP; and

(2) may be updated by the OMPP as needed.

(b) Prior authorization is required as follows:

(1) A ~~consumer~~ **member** uses all units of one (1) or more of the services authorized in the service package within the defined service package term, and additional units of that service are needed.

(2) A ~~consumer~~ **member** needs a service that is not authorized within a service package.

(3) A service package provided through a certified DMHA ACT team.

(4) A ~~consumer~~ **member** who is denied an MRO service package may submit prior authorization for a specific MRO service.

(5) Services may be prior authorized for retroactive Medicaid eligibility periods.

(c) Providers who may submit prior authorization, as referenced in 405 IAC 5-3-13, include any of the following:

(1) A doctor of medicine.

(2) A doctor of osteopathy.

(3) ~~A~~ **An** HSPP.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-17; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 212. 405 IAC 5-21.6-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-2 Definitions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

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

(b) "Adult mental health habilitation" or "AMHH" services refers to medical or remedial services recommended

by a physician or other licensed professional, within the scope of his or her practice, for the habilitation of a mental health disability and the restoration or maintenance of an individual's best possible functional level. Services are clinical and supportive behavioral health services that are provided for individuals, families, or groups of adult persons who:

(1) are living in the community; and

(2) need aid on a routine basis for a mental illness or co-occurring mental illness and addiction disorders.

(c) "AMHH behavioral health habilitation services" include the following:

(1) Adult day services.

(2) Home and community-based habilitation and support.

(3) Respite care.

(4) Therapy and behavior support services.

(5) Addiction counseling.

(6) Peer support services.

(7) Supported community engagement services.

(8) Care coordination.

(9) Medication training and support.

~~(d) "Approved division of mental health and addiction (DMHA) behavioral health assessment tool" means the state designated assessment tool administered by a qualified individual who is trained and DMHA-certified to administer the tool in order to assist in determining the level of need and functional impairment of an applicant or a recipient.~~

~~(e)~~ **(d)** "Authorized health care professional" or "AHCP" means any of the following persons:

(1) A physician assistant with authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.

(2) A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

~~(f)~~ **(e)** "Detoxification services" means services or activities that are provided to a ~~recipient~~ **member** during his or her withdrawal from alcohol and other addictive drugs, while under the direct supervision of a physician or clinical nurse specialist.

~~(g)~~ **(f)** "DMHA" means the division of mental health and addiction.

~~(h)~~ **(g)** "Habilitation services" means activities that are designed to assist ~~recipients~~ **members** in acquiring, retaining, and improving the following skills necessary to reside successfully in a community setting:

(1) Self-help.

(2) Socialization.

(3) Adaptive skills.

~~(i)~~ **(h)** "Individualized integrated care plan" or "IICP" means a treatment plan that:

(1) integrates all components and aspects of care that are:

(A) deemed medically necessary;

(B) clinically indicated; and

(C) provided in the most appropriate setting to achieve the ~~recipient's~~ **member's** goals;

(2) includes all indicated medical and support services needed by the ~~recipient~~ **member** in order to:

(A) remain in the community;

(B) function at the highest level of independence possible; and

(C) achieve goals identified in the IICP;

(3) is developed for each ~~recipient;~~ **member;**

(4) is developed with the ~~recipient;~~ **member;** and

(5) reflects the ~~recipient's~~ **member's** desires and choices.

~~(j)~~ **(i)** "Level of need" means a recommended intensity of behavioral health services based on a pattern of a ~~recipient's~~ **member's** needs, as determined by using a standardized assessment tool.

~~(k)~~ **(j)** "Licensed professional" means any of the following persons:
(1) A licensed psychiatrist.
(2) A licensed physician.
(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
(4) A licensed clinical social worker (LCSW).
(5) A licensed mental health counselor (LMHC).
(6) A licensed marriage and family therapist (LMFT).
(7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

~~(l)~~ **(k)** "Medicaid rehabilitation services" means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of that individual's practice under state law, for:
(1) maximum reduction of physical or mental health disability; and
(2) restoration to a ~~recipient's~~ **member's** best possible level of functioning.

~~(m)~~ **(l)** "Nonprofessional caregiver" means any individual who does not receive compensation for providing care or services to a ~~Medicaid recipient.~~ **member.**

~~(n) "Office" refers to the office of Medicaid policy and planning.~~

(m) "Office-approved behavioral health assessment tool" means the state designated assessment tool administered by a qualified individual who is trained and office-certified to administer the tool in order to assist in determining the level of need and functional impairment of an applicant or a member.

~~(o)~~ **(n)** "Other behavioral health professional" **or** "OBHP" means any of the following:
(1) An individual with an associate's or bachelor's degree, or equivalent behavioral health experience:
(A) meeting minimum competency standards set forth by a behavioral health service provider; and
(B) supervised by either a licensed professional or a QBHP.
(2) A licensed addiction counselor, as defined under IC 25-23.6-10.5, supervised by either a licensed professional or a QBHP.

~~(p)~~ **(o)** "Professional caregiver" means an individual who receives payment for providing services and supports to a ~~Medicaid recipient.~~ **member.**

~~(q)~~ **(p)** "Provider agency" means any ~~DMHA~~ **office**-approved agency that meets the qualifications and criteria to become an AMHH provider agency, as required by this rule.

~~(r)~~ **(q)** "Provider staff" means any individual working under ~~a DMHA~~ **an office**-approved AMHH provider agency that meets the qualifications and requirements mandated by the AMHH service being provided, as defined in this rule.

~~(s)~~ **(r)** "Qualified behavioral health professional" or "QBHP" means any of the following:
(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines from an accredited university:
(A) Psychiatric or mental health nursing, plus a license as a registered nurse in Indiana.
(B) Pastoral counseling.
(C) Rehabilitation counseling.
(2) An individual who:
(A) is under the supervision of a licensed professional;
(B) is eligible for and working towards professional licensure; and
(C) has completed a master's or doctoral degree, or both, in any of the following disciplines from an accredited university:
(i) Social work from a university accredited by the Council on Social Work Education.
(ii) Psychology.
(iii) Mental health counseling.

(iv) Marital and family therapy.

(3) A licensed, independent practice, school psychologist under the supervision of a licensed professional.

(4) An authorized health care professional (AHCP) who is one (1) of the following:

(A) A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.

(B) A nurse practitioner or clinical nurse specialist, with prescriptive authority, performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

~~(t)~~ **(s)** "Skills training" means services or activities to further the reinforcement, management, adaptation, and retention of skills necessary for a ~~recipient~~ **member** to live successfully in the community.

~~(u)~~ **(t)** "State evaluation team" means the ~~DMHA~~ **office** independent evaluation team that will review and assess all evaluation information and supporting clinical documentation collected for AMHH applicants and ~~recipients~~ **members** and will be responsible for making final determinations regarding the following:

(1) Eligibility of applicants for AMHH services.

(2) Authorization for AMHH services for eligible ~~recipients.~~ **members.**

(3) Continued eligibility determination for AMHH ~~recipients.~~ **members.**

(4) Appropriate service delivery to AMHH ~~recipients,~~ **members,** as a result of conducting quality improvement reviews of AMHH service provider agencies.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-2; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 213. 405 IAC 5-21.6-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-3 Applicants and the application process

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 3. (a) In order for an individual to receive services under this rule, an AMHH eligible provider agency, in collaboration with the individual seeking services, must submit an application in the manner required by the office. ~~and the DMHA.~~

(b) Each applicant for AMHH services must receive a face-to-face evaluation using the:

(1) ~~DMHA~~ **office**-approved behavioral health assessment tool; and

(2) application form developed by the office. ~~and DMHA.~~

(c) The application form and supporting documentation may include the following information about the applicant:

(1) Current and historical health status.

(2) Behavioral health issues.

(3) Functional needs.

(d) An application must, at a minimum, include documentation indicating the following:

(1) The applicant is requesting the service or services listed on the proposed IICP submitted with the application.

(2) The applicant chose, from a randomized list of eligible AMHH service providers in the applicant's community, a provider to deliver the ~~DMHA~~ **office** authorized AMHH services under this rule.

(e) Upon receipt of the application and supporting clinical documentation, the ~~DMHA~~ state evaluation team will assess the submitted information and determine whether or not the applicant meets the core eligibility criteria for receiving AMHH services.

(f) The responsibility for eligibility determination and approval of all proposed AMHH services included in the IICP is retained by the ~~DMHA~~ state evaluation team, in order to prevent a conflict of interests.

(g) Any approval or denial of services under this rule will be communicated to the:
(1) applicant or the applicant's authorized representative; and
(2) referring provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-3; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 214. 405 IAC 5-21.6-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-4 Eligibility

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 4. (a) An applicant may be eligible for participation in the AMHH services program if the applicant meets all of the following core criteria:
(1) The applicant is enrolled in Medicaid.
(2) The applicant is at least thirty-five (35) years of age or older.
(3) The applicant is unlikely to make improvements in a variety of life domains, with such a determination being based on the state evaluation team's review of all relevant referral materials.
(4) Based upon the ~~DMHA~~ **office**-approved behavioral health assessment tool, the applicant has a recommendation for intensive community-based care, as indicated by a rating level of four (4) or higher.
(5) The applicant has been diagnosed with an AMHH-eligible primary mental health diagnosis, which may include, but is not limited to, any of the following general categories:
(A) Schizophrenic disorder.
(B) Major depressive disorder.
(C) Bipolar disorder.
(D) Delusional disorder.
(E) Psychotic disorder.
(6) The applicant either:
(A) resides in a community-based setting that is not an institutional setting; or
(B) will be discharged from an institutional setting back to a community-based setting.
(7) Based on the behavioral health clinical evaluation, the applicant must meet all of the following needs-based criteria:
(A) Without ongoing habilitation services, as demonstrated by written attestation from a psychiatrist or a health services provider in psychology (HSPP) as defined in IC 25-33-1-5.1, the applicant will likely deteriorate and be at risk of institutionalization.
(B) The applicant demonstrates the need for significant assistance in major life domains related to the applicant's mental illness, for example, the following:
(i) Physical problems.
(ii) Social functioning.
(iii) Basic living skills.
(iv) Self-care.
(v) A potential for harm to the self or to others.
(C) The applicant demonstrates significant needs related to the applicant's behavioral health.
(D) The applicant demonstrates:
(i) significant impairment in self-management of the applicant's mental illness; or
(ii) significant needs for assistance with mental illness management.
(E) The applicant demonstrates a lack of sufficient natural supports to assist with mental illness management.
(F) The applicant is not a danger to the self or others at the time the application for AMHH service eligibility is submitted for state review and determination.

(b) For purposes of this section, the following definitions apply:
(1) "Assistance" means any kind of support given, due to a mental health condition or disorder, including, but not limited to, the following:
(A) Mentoring.
(B) Supervision.
(C) Reminders.

(D) Verbal cuing.
(E) Hands-on assistance.
(2) "Significant" means an assessed need for immediate or intensive action due to a serious or disabling need.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-4; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 215. 405 IAC 5-21.6-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-5 Eligibility period; renewal

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 5. (a) A ~~recipient~~ **member** who is approved to receive AMHH services under this rule shall be eligible for such services for up to a twelve (12) month period, as long as eligibility and needs-based criteria continue to be met.

(b) A reevaluation will be conducted at least every twelve (12) months and shall include the following:
(1) A face-to-face holistic clinical and biopsychosocial evaluation completed by ~~a DMHA~~ **an office**-approved AMHH service provider.
(2) Administration of the ~~DMHA~~ **office**-approved behavioral assessment tool to determine whether the ~~recipient~~ **member** still meets the level of need for intensive community-based services, as demonstrated by a rating level of four (4) or higher.
(3) Assessment of the ~~recipient's~~ **member's** progress towards meeting treatment goals on the IICP.
(4) Documentation that the ~~recipient~~ **member** continues to meet AMHH financial, target group eligibility, and needs-based criteria.
(5) An updated referral application.
(6) An updated IICP documenting the ~~recipient's~~ **member's** choice of AMHH service or services and AMHH service providers.

(c) The ~~DMHA~~ **state** evaluation team will review and assess the renewal application and reevaluation results to determine whether the ~~recipient~~ **member** continues to meet AMHH eligibility.

(d) Any approval or denial of eligibility and services under this rule will be communicated to the:
(1) applicant or the applicant's authorized representative; and
(2) referring provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-5; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 216. 405 IAC 5-21.6-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-6 Clinical documentation requirements

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 6. (a) To be reimbursable under this rule, the AMHH service must be supported by clinical documentation that is maintained in the ~~recipient's~~ **member's** clinical record.

(b) The documentation required to support billing for an AMHH services must meet the following standards:
(1) Focus on recovery and habilitation.
(2) Emphasize ~~consumer~~ **member** strengths.
(3) Reflect progress toward the habilitation goals reflected in the ~~recipient's~~ **member's** IICP.
(4) Be updated with every ~~recipient~~ **member** encounter when billing is submitted for reimbursement.
(5) Be written and signed by the agency staff rendering services.

(c) For a ~~recipient~~ **member** participating in any AMHH service, the clinical documentation must contain the following information:
(1) The type of service being provided.
(2) The names and qualifications of the staff providing the service.
(3) The location or setting where the service was provided.
(4) The focus of the session or service delivered to or on behalf of the ~~recipient.~~ **member.**
(5) The ~~recipient's~~ **member's** symptoms, needs, goals, or issues addressed during the session.
(6) The duration of the service (actual time spent).
(7) Start and end time of the service.
(8) The ~~recipient's~~ **member's** IICP goal or goals being addressed during the session.
(9) The progress made toward meeting habilitation goals noted on the IICP.
(10) The date of service rendered, including month, day, and year.

(d) The content of the documentation must support the amount of time billed.

(e) For ~~recipients~~ **members** participating in AMHH services in a group setting, documentation must be provided for each encounter and must include the following:
(1) The focus of the group or session.
(2) The ~~consumer's~~ **member's** level of activity in the group session.
(3) How the service:
(A) benefits the ~~recipient;~~ **member;** and
(B) assists the ~~recipient~~ **member** in reaching the ~~recipient's~~ **member's** habilitation goals.

(f) For AMHH services provided on behalf of the ~~recipient~~ **member** without the ~~recipient~~ **member** present, documentation must be provided for each encounter and must include the following information:
(1) The name or names of the person or persons attending the session and each person's relationship to the ~~recipient.~~ **member.**
(2) How the service:
(A) benefits the ~~recipient;~~ **member;** and
(B) assists the ~~recipient~~ **member** in reaching the ~~recipient's~~ **member's** habilitation goals.

(g) In addition to the requirements listed in this section, specific requirements for selected service types may be required and are reflected in other sections of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-6; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 217. 405 IAC 5-21.6-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-7 Coverage requirements; limits

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 7. (a) For an AMHH service to be reimbursable under this rule, the service must:
(1) be listed in this rule as a covered service;
(2) be habilitative in nature;
(3) promote ~~recipient~~ **member** stability;
(4) demonstrate the ~~recipient's~~ **member's** movement toward the individual goals identified in the ~~recipient's~~ **member's** IICP; and
(5) continue to provide a benefit to the ~~recipient.~~ **member.**

(b) The following services are covered under the AMHH services program according to the coverage criteria, limitations, and procedures specified in this rule:
(1) Adult day services.
(2) Home and community-based habilitation and support.
(3) Respite care.
(4) Therapy and behavioral support services.

(5) Addiction counseling (substance-related disorder).
(6) Peer support services.
(7) Supported community engagement services.
(8) Care coordination services.
(9) Medication training and support.

(c) The following services will not be covered and are not eligible for reimbursement under this rule:
(1) A service provided to the ~~recipient~~ **member** at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, state, local, and private entities.
(2) A service that is provided while the ~~recipient~~ **member** is in an institutional or noncommunity-based setting.
(3) A service provided as a diversionary, leisurely, or recreational activity that is not a component of an authorized respite care service.
(4) A service that is provided in a manner that is not within the scope or limitations of an AMHH service.
(5) A service that is not documented as a covered or approved service on the ~~recipient's DMHA~~ **member's office**-approved IICP.
(6) A service that is not supported by documentation in the ~~recipient's~~ **member's** clinical record.
(7) A service provided that exceeds the defined limits of the service, including service quantity, limits, duration, or frequency.
(8) An activity that is excluded from the service scope or definition.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-7; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 218. 405 IAC 5-21.6-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-8 Adult day services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-14.5; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 8. (a) The services reimbursable as adult day services consist of community-based group programs designed to meet the needs of adults with significant behavioral health impairments as identified in a ~~recipient's~~ **member's** IICP. These comprehensive, nonresidential programs provide health, wellness, social, and therapeutic activities. The day services are delivered in a structured, supportive environment and provide the ~~recipient~~ **member** with supervision, support services, and personal care as required by the ~~recipient's~~ **member's** IICP.

(b) Adult day services may include any of the following services as they relate to the ~~recipient's~~ **member's** IICP:
(1) Care planning.
(2) Treatment.
(3) Monitoring of weight, blood glucose level, and blood pressure.
(4) Medication administration.
(5) Nutritional assessment and planning provided by a certified ~~dietician.~~ **dietitian.**
(6) Individual or group exercise training.
(7) Reinforcement of established skills and may include activities of daily living.
(8) Other social activities.

(c) Provider staff of adult day services must meet any of the following qualifications:
(1) Be a licensed professional, except for a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.
(2) Be a QBHP.
(3) Be an OBHP.

(d) The agency staff member providing adult day services must receive supervision by a licensed professional.

(e) Medication administration provided as an adult day service must be delivered within the individual's scope of practice, as defined by federal and state law, by an agency staff member who meets one (1) of the following qualifications:
(1) A licensed physician.

(2) An authorized health care professional (AHCP).
(3) A registered nurse.
(4) A licensed practical nurse (LPN).
(5) A medical assistant who has graduated from a two-year clinical program.

(f) A certified ~~dietician~~ **dietitian** providing nutritional assessment and planning as a part of the adult day service must meet the qualifications in IC 25-14.5.

(g) Adult day service standards include all of the following requirements:
(1) The service requires face-to-face contact with the ~~recipient.~~ **member.**
(2) The ~~recipient~~ **member** must be the focus of the service delivered.
(3) Clinical oversight must be provided by a licensed physician, who is:
(A) on-site at least once a week; and
(B) available to program staff when not physically present on-site.
(4) Each service must be documented in the ~~recipient's~~ **member's** clinical record.
(5) At least weekly, a designated clinical staff member must:
(A) review the ~~recipient's~~ **member's** progress toward meeting habilitative goals; and
(B) document the ~~recipient's~~ **member's** progress in the clinical record.

(h) Services provided in a residential setting are not reimbursable as adult day services under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-8; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 219. 405 IAC 5-21.6-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-9 Home and community-based habilitation and support services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 9. (a) The services available as home and community-based habilitation and support services are intended to:
(1) provide skills training to reinforce established skills (and may include activities of daily living);
(2) assist in the management, adaptation, and retention of skills necessary to support the ~~recipient's~~ **member's** needs; and
(3) assist the ~~recipient~~ **member** to gain an understanding of the self-management of behavioral and medical health conditions.

(b) The services may be reimbursable as either of the following:
(1) Services provided to an individual in either an individual setting or a group setting.
(2) Services provided to family members or other nonprofessional caregivers in an individual or group setting with or without the individual present.

(c) The services reimbursable under individual or any other subcategory of the service with the ~~recipient~~ **member** present must meet the following requirements:
(1) Involve face-to-face contact directed at the health, safety, and welfare of the individual.
(2) Be provided in the individual's home or living environment or other community-based settings outside of a clinic or office environment.

(d) The services reimbursable under either a family setting or as a couple, with or without the ~~recipient~~ **member** present, must meet the following requirements:
(1) Involve face-to-face contact with family members or nonprofessional caregivers directed at the health, safety, and welfare of the ~~recipient~~ **member** and assisting in the acquisition, improvement, and retention of skills necessary to support ~~recipients~~ **members** to live successfully in the community.
(2) Include training and education about the treatment regimens appropriate to the ~~recipient~~ **member** to instruct:
(A) a parent;

(B) another family member identified in the IICP; or
(C) a primary caregiver.
(3) Improve the ability of the parent, family member, or primary caregiver to provide care to or for the ~~recipient.~~ **member.**
(4) Be focused on the ~~recipient~~ **member** and be linked to the needs and goals identified on the ~~recipient's~~ **member's** IICP.

(e) Agency staff must meet any of the following qualifications to provide services under this section:
(1) Be a licensed professional, except for a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.
(2) Be a QBHP.
(3) Be an OBHP.

(f) Home and community-based habilitation and support service standards include the following:
(1) Face-to-face contact with the ~~recipient,~~ **member,** family members, or nonprofessional caregivers in an individual setting or group setting.
(2) Activities that include:
(A) implementation of the IICP;
(B) assistance with personal care; or
(C) coordination and facilitation of medical and nonmedical services to meet health care needs.
(3) Services under this subsection may include, but are not limited, to the following:
(A) Skills training in:
(i) food planning and preparation;
(ii) money management; and
(iii) maintenance of living environment.
(B) Training in the appropriate use of community services.
(C) Training in skills needed to locate and maintain a home.
(D) Medication-related education and training by nonmedical staff.

(g) The following services are not reimbursable under this section:
(1) Job coaching.
(2) Activities purely for recreation or diversion.
(3) Academic tutoring.
(4) A service provided to a professional caregiver.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-9; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 220. 405 IAC 5-21.6-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-10 Respite care services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 10. (a) The services reimbursable as respite care services are provided to a ~~recipient~~ **member** who is:
(1) unable to care for himself or herself; and
(2) living with a nonprofessional caregiver.

(b) The service provided under this section shall be furnished on a short-term basis because of a nonprofessional caregiver's absence or need for relief.

(c) The service may be provided in any of the following locations:
(1) A ~~recipient's~~ **member's** home or place of residence.
(2) A caregiver's home.
(3) A nonprivate residential setting such as a group home or adult foster care.

(d) Provider staff delivering service under this section must meet one (1) of the following qualifications:

(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.

(e) Medication administration provided within the respite care service must be provided within the scope of practice, as defined by federal and state law, by an agency staff member who meets one (1) of the following qualifications:
(1) A physician.
(2) An advanced practice nurse (APN).
(3) A physician assistant (PA).
(4) A registered nurse (RN).
(5) A licensed practical nurse (LPN).

(f) Respite care service standards include the following:
(1) The ~~recipient~~ **member** must be living with a nonprofessional caregiver.
(2) The location of services and the level of professional care are based on the needs of the ~~recipient~~ **member** of the service, including the regular monitoring of medications or behavioral symptoms as identified in the ~~recipient's~~ **member's** IICP.
(3) Services must be provided in the least restrictive environment available and ensure the health and welfare of the ~~recipient.~~ **member.**
(4) Services shall not be used as a substitute for regular care in order to allow the ~~recipient's~~ **member's** caregiver to:
(A) attend school;
(B) hold a job; or
(C) engage in employment or employment search related activities.
(5) Respite care must not duplicate any other service being provided under the ~~recipient's~~ **member's** IICP.

(g) The following services are not reimbursable under this section:
(1) Services provided to a ~~recipient~~ **member** living in ~~a DMHA~~ **an office**-licensed residential facility.
(2) Services provided to a ~~recipient~~ **member** who receives in-home support from a professional caregiver, rather than a nonpaid caregiver.
(3) Respite care services provided by either of the following:
(A) Any relative who is the primary caregiver of the ~~recipient.~~ **member.**
(B) Anyone living in the ~~recipient's~~ **member's** home or residence.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-10; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 221. 405 IAC 5-21.6-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-11 Therapy and behavioral support services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 11. (a) The services reimbursable as therapy and behavioral support services include the following:
(1) Services provided in an individual or a group setting.
(2) Services provided to family members or other nonprofessional caregivers in an individual or group setting, with or without the ~~recipient~~ **member** present.

(b) Services provided to a ~~recipient~~ **member** must be:
(1) time-limited;
(2) structured; and
(3) provided in a face-to-face session.

(c) Services provided must meet the following requirements:
(1) Be provided either at home or at locations outside the clinic setting.
(2) Be provided in an individual setting or a group setting.
(3) Be a face-to-face interaction with ~~recipient,~~ **the member,** family members, or nonprofessional caregivers

supporting a ~~recipient.~~ **member.**
(4) The ~~recipient~~ **member** must be the focus of the service.

(d) Provider staff delivering services under this subsection must meet one (1) of the following qualifications:
(1) Be a licensed professional, as defined in this rule, except not a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.
(2) Be a QBHP.

(e) Therapy and behavioral support service standards include the following:
(1) Observation of the ~~recipient~~ **member** and environment for purposes of the development of the IICP.
(2) Development of a person-centered behavioral support plan and subsequent revisions that may be a part of the IICP.
(3) Therapy and support activities include, but are not limited to, the following:
(A) Assertiveness training.
(B) Stress reduction techniques.
(C) Development of socially accepted behaviors.
(D) Implementation of a behavior support plan for staff, family members, roommates, and other appropriate individuals.

(f) The services are not reimbursable under this section if provided in a clinic setting.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-11; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 222. 405 IAC 5-21.6-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-12 Addiction counseling services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 12. (a) The services reimbursable as addiction counseling services include the following:
(1) Services provided to the ~~recipient~~ **member** either individually or in a group setting.
(2) Services provided to family members or other nonprofessional caregivers in an individual or group setting, with or without the ~~recipient~~ **member** present.

(b) Services shall meet the following standards:
(1) Be provided face-to-face with the ~~recipient,~~ **member,** family members, or nonprofessional caregivers.
(2) Be provided by qualified addiction professionals or other clinicians.
(3) Include any of the following:
(A) Education on addiction disorders.
(B) Skills training in:
(i) communication;
(ii) anger management;
(iii) stress management; and
(iv) relapse prevention.
(C) Referral to community recovery support programs, if available.

(c) Services under this section may be provided to adult ~~recipients~~ **members** with:
(1) a substance-related disorder; and
(2) any of the following:
(A) Minimal or manageable medical conditions.
(B) Minimal withdrawal risk.
(C) Emotional, behavioral, and cognitive conditions that will not prevent the ~~recipient~~ **member** from benefitting from this service.

(d) All services may be provided in an individual or group setting, but the ~~recipient~~ **member** must always be the focus of addiction counseling.

(e) Provider staff delivering services under this section must meet one (1) of the following qualifications:
(1) A licensed professional as defined under this rule.
(2) A QBHP.

(f) The following services are not reimbursable under this section:
(1) Services provided to a ~~recipient~~ **member** with withdrawal risk or symptoms.
(2) Services provided to a ~~recipient.~~ **member:**
(A) whose needs cannot be managed safely with AMHH services; or
(B) who needs detoxification services.
(3) Services provided to a ~~recipient~~ **member** who is determined to be at imminent risk of harm to the self or to others.
(4) Addiction counseling sessions that consist only of education.
(5) Services provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-12; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 223. 405 IAC 5-21.6-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-13 Peer support services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 13. (a) The services reimbursable as peer support services must be:
(1) provided face-to-face;
(2) structured; and
(3) scheduled activities that promote all of the following:
(A) Socialization.
(B) Recovery.
(C) Self-advocacy.
(D) Development of natural supports.
(E) Maintenance of community living skills.

(b) The provider agency staff member delivering services under this section must meet one (1) of the following qualifications:
(1) The ~~DMHA~~ **office** training and competency standards for a certified recovery specialist.
(2) Be an individual under the supervision of a:
(A) licensed professional; or
(B) QBHP.

(c) At a minimum, the services provided under this section must include components that:
(1) assist ~~recipients~~ **members** with:
(A) developing IICPs; and
(B) other formal mentoring activities aimed at increasing the active participation of ~~recipients~~ **members** in person-centered planning and delivery of individualized services;
(2) assist ~~recipients~~ **members** with the development of psychiatric advanced directives;
(3) support ~~recipients~~ **members** in problem-solving related to reintegration into the community; and
(4) provide education to ~~recipients~~ **members** and promote the recovery process and anti-stigma activities.

(d) The following services are not reimbursable under this section:
(1) Services provided in group settings.
(2) Activities billable under home and community-based habilitation services.
(3) Care coordination services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-13; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 224. 405 IAC 5-21.6-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-14 Supported community engagement services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 14. (a) Services reimbursable as supported community engagement services must meet the following requirements:

(1) Be provided face-to-face with the ~~recipient~~ **member** in an individual setting.

(2) Consist of services that engage a ~~recipient~~ **member** in meaningful community involvement in activities such as volunteerism or community service.

(3) Consist of services aimed at developing skills and opportunities that lead to improved integration of the ~~recipient~~ **member** into the community through increased community engagement.

(b) The provider agency staff member delivering services under this section must meet one (1) of the following qualifications:

(1) A licensed professional.

(2) A QBHP.

(3) An OBHP.

(c) Supported community engagement service standards include the following:

(1) The service is provided to a ~~recipient~~ **member** who:

(A) may benefit from community engagement; and

(B) is unlikely to achieve this involvement without the provision of support.

(2) Assistance is provided to the ~~recipient~~ **member** in developing relationships with community organizations specific to the ~~recipient's~~ **member's** interests and needs.

(3) The service is for the purpose of achieving a generalized skill or behavior that may prepare the ~~recipient~~ **member** for an employment setting and may include, but is not limited to, focus on the following concepts:

(A) Attendance.

(B) Task completion.

(C) Problem solving.

(D) Safety.

(d) The following services are not reimbursable under this section:

(1) A provider agency's compensation to a ~~recipient.~~ **member.**

(2) Training in specific job tasks.

(3) Services provided to a ~~recipient~~ **member** who is currently competitively employed.

(4) Vocational rehabilitation services funded under the Rehabilitation Act of 1973.

(5) Services provided in a group setting.

(6) Services that include explicit employment objectives.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-14; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 225. 405 IAC 5-21.6-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-15 Care coordination services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 15. (a) The services reimbursable as care coordination services consist of services that assist a ~~recipient~~ **member** in gaining access to needed medical, social, educational, and other services, including the following:

(1) Direct assistance in gaining access to services.

(2) Coordination of care.

(3) Oversight of the ~~recipient's~~ **member's** care in the AMHH services program.

(4) Linkage of the ~~recipient~~ **member** to appropriate services.

(b) For purposes of this section, care coordination includes the following services:
(1) Needs assessment.
(2) IICP development.
(3) Referral and linkage.
(4) Monitoring and follow-up.
(5) Evaluation.

(c) Provider staff delivering services under this section must meet one (1) of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.

(d) Agency staff providing services must provide:
(1) direct assistance in gaining access to necessary medical, social, educational, and other services; and
(2) referrals to services, activities, or contacts necessary to ensure that the IICP:
(A) is effectively implemented; and
(B) adequately addresses the mental health or addiction needs, or both, of the eligible ~~recipient.~~ **member.**

(e) The following services may be provided under the care coordination services identified under subsection (b):
(1) A needs assessment consists of identifying the ~~recipient's~~ **member's** needs for any medical, educational, social, or other services. Specific assessment activities necessary to form a complete needs assessment of the ~~recipient~~ **member** may include:
(A) documenting the ~~recipient's~~ **member's** history;
(B) identifying the ~~recipient's~~ **member's** needs;
(C) completing related documentation; or
(D) gathering information from other sources, such as:
(i) family members; or
(ii) medical providers.
(2) The IICP development activities include the development of a written IICP based upon the information collected through the needs assessment phase. The IICP shall identify the habilitation activities and assistance needed to accomplish the ~~recipient's~~ **member's** objectives.
(3) Referral and linkage include activities that help link the ~~recipient~~ **member** with:
(A) medical providers;
(B) social service providers;
(C) educational providers; and
(D) other programs and services that are capable of providing habilitative services that meet the ~~recipient's~~ **member's** needs.
(4) Monitoring and follow-up activities:
(A) include making contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the needs of the ~~recipient;~~ **member;** and
(B) may include activities and contacts with the following individuals:
(i) The ~~recipient.~~ **member.**
(ii) Family members or others who have a significant relationship with the ~~recipient.~~ **member.**
(iii) Nonprofessional caregivers.
(iv) Providers.
(v) Other entities.
(5) Evaluation activities include face-to-face contact with the ~~recipient~~ **member** at least every ninety (90) days for the following reasons:
(A) To ensure the IICP is effectively implemented and adequately addresses the ~~recipient's~~ **member's** needs.
(B) To determine if the services are consistent with the IICP and any changes to the IICP.
(C) To make changes or adjustments to the IICP in order to meet the ~~recipient's~~ **member's** ongoing needs.
(D) To evaluate or reevaluate the ~~recipient's~~ **member's** progress toward achieving the IICP's objectives.

(f) The time devoted to formal supervision between the care coordinator and the licensed supervisor to review the ~~recipient's~~ **member's** care and treatment shall be:
(1) an included care coordination activity;
(2) documented accordingly in the ~~recipient's~~ **member's** clinical record; and

(3) billed under only one (1) provider staff member.

(g) The following services are not reimbursable under this section:
(1) The direct delivery of medical, clinical, or other direct services.
(2) Services provided in a group setting, including, but not limited to, the following:
(A) Training in daily living skills.
(B) Training in work or social skills.
(C) Grooming and other personal services.
(D) Training in housekeeping, laundry, and cooking.
(E) Transportation services.
(F) Individual, group, or family therapy services.
(G) Crisis intervention services.
(3) Services that go beyond assisting a ~~recipient~~ **member** in gaining access to needed services including, but not limited to, the following:
(A) Paying bills.
(B) Balancing the ~~recipient's~~ **member's** checkbook.
(C) Traveling to and from appointments with a ~~recipient~~ **member** or ~~recipients.~~ **members.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-15; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 226. 405 IAC 5-21.6-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-16 Medication training and support services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 16. (a) The services reimbursable as medication training and support services include the following:
(1) Services provided to the ~~recipient~~ **member** in an individual or in a group setting.
(2) Services provided to family members or other nonprofessional caregivers in an individual or a group setting with or without the ~~recipient~~ **member** present.

(b) The following services are reimbursable and must be provided face-to-face in either an individual or a group setting:
(1) Monitoring medication compliance.
(2) Medication training and support.
(3) Monitoring medication side effects.
(4) Providing other nursing or medical assessments.

(c) A provider agency may receive reimbursement for training family members or nonprofessional caregivers to perform the activities identified in this section.

(d) When provided to family members or other nonprofessional caregivers, the service:
(1) must focus on and be on behalf of the ~~recipient;~~ **member;** and
(2) may include the training of family members or nonprofessional caregivers to:
(A) monitor the ~~recipient's~~ **member's** medication compliance;
(B) assist with the administration of prescribed medications; and
(C) monitor side effects, including:
(i) weight;
(ii) blood glucose level; and
(iii) blood pressure.

(e) Medication training and support may also include the following services that are not required to be provided face-to-face with the ~~recipient.~~ **member:**
(1) Transcribing medication orders of the following:
(A) A physician.
(B) An AHCP.
(2) Setting or filling medication boxes.

(3) Consulting with the attending ~~physician~~ **provider** or AHCP regarding medication-related issues.
(4) Ensuring linkage that lab and other prescribed clinical orders are sent.
(5) Ensuring that the ~~recipient~~ **member** follows through and receives lab work and services pursuant to other clinical orders.
(6) Follow-up reporting of lab and clinical test results to the ~~recipient~~ **member** and physician.

(f) Services provided that are not face-to-face with the ~~recipient~~ **member** must meet the following standards:
(1) The ~~recipient~~ **member** must be the focus of the service.
(2) Documentation must support how the service benefits the ~~recipient.~~ **member.**

(g) When provided in a clinic setting, medication training and support may compliment, but not duplicate, activities associated with medication management activities available under the Medicaid clinic option.

(h) When provided in a residential treatment setting, medication training and support may include components of medication management services as defined under the Medicaid clinic option.

(i) Provider staff delivering services under this section must meet one (1) of the following qualifications:
(1) A licensed physician.
(2) An ~~authorized health care professional~~ AHCP.
(3) A licensed registered nurse (RN).
(4) A licensed practical nurse (LPN).
(5) A medical assistant (MA) who has graduated from a two-year clinical program.

(j) The services under this section must be provided within the practitioner's scope of practice as defined by federal and state law.

(k) The following services are not reimbursable under this section:
(1) Medication management, counseling, or psychotherapy when medication management is a component of the service.
(2) Medication training and support that is billed separately for the same visit by the same provider.
(3) Coaching and instruction regarding a ~~recipient's~~ **member's** self-administration of medications.
(4) Services provided to paid, professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-16; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 227. 405 IAC 5-21.6-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-17 AMHH provider agency requirements

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 17. (a) In order to provide AMHH services under this rule, a provider must be authorized by the ~~DMHA~~ **office** as an AMHH services provider agency.

(b) Provider agencies under this rule must attest that the individual provider staff member delivering an AMHH service meets the service-specific provider requirements and qualifications as defined within this rule.

(c) The ~~DMHA and the~~ office ~~have~~ **has** deemed state-certified community mental health centers (CMHCs) as being in good standing as ~~DMHA~~ **office**-approved AMHH services provider agencies.

(d) Any provider wishing to apply to become an AMHH provider agency must:
(1) complete an AMHH provider agency application; and
(2) submit the application to the ~~DMHA~~ **office** for review and consideration.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-17; filed Dec 16, 2013, 9:11 a.m.:

20140115-IR-405130183FRA)

SECTION 228. 405 IAC 5-21.6-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-18 Fair hearings and appeals

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 18. (a) Any of the following may appeal an action by the ~~DMHA~~ **office** state evaluation team and request an administrative hearing:
(1) An applicant.
(2) A ~~recipient~~ **member** of services under this rule.
(3) A duly authorized representative of the following:
(A) An applicant.
(B) A ~~recipient.~~ **member.**

(b) An individual, an applicant, or a ~~recipient~~ **member** appealing an action under this rule must follow the appeal processes and procedures in 405 IAC 1.1.

(c) Administrative hearings and appeals by an applicant or ~~recipient~~ **member** are governed by the procedures, time limits, provisions, and requirements set out in 405 IAC 1.1.

(d) In the event that the ~~DMHA~~ state evaluation team denies an applicant eligibility for AMHH services or authorization for a submitted IICP requesting AMHH services, the ~~DMHA~~ state evaluation team shall notify the following individuals of the AMHH denial determination:
(1) The applicant.
(2) The ~~recipient~~ **member** of AMHH services under this rule.
(3) The duly authorized representative of the applicant or the ~~recipient,~~ **member,** if applicable.
(4) The AMHH provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-18; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 229. 405 IAC 5-21.6-19 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.6-19 Complaints and grievances

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 19. (a) Any of the following shall have the right to file a written complaint or a written grievance with the state ~~the DMHA,~~ or the office:
(1) An applicant.
(2) A ~~recipient.~~ **member.**
(3) A duly authorized representative or representatives of an applicant or a ~~recipient.~~ **member.**

(b) A complaint or grievance regarding an AMHH provider agency or a provider shall be accepted by the following means:
(1) The family/consumer section on the DMHA website.
(2) The consumer service line (800-901-1133).
(3) In-person via a DMHA staff member.
(4) A written complaint or e-mail submitted to the DMHA.

(c) Upon receipt of a complaint or a grievance, the ~~DMHA~~ **office** shall:
(1) log the complaint or grievance; and
(2) initiate an investigation.

(d) After the investigation is complete, the ~~DMHA~~ **office** shall notify the individual or the ~~recipient~~ **member** filing the complaint or grievance of the ~~DMHA's~~ **office's** findings.

(e) The ~~DMHA~~ **office** decision with regard to a complaint or a grievance:
(1) may not be appealed; and
(2) does not grant any appeal rights to the individual or the ~~recipient~~ **member** filing a complaint or grievance.

(f) The filing of a complaint or grievance is not a prerequisite to filing an appeal under section 18 of this rule.

(g) If the ~~DMHA~~ **office** sends a letter to a provider agency under this section stating its findings regarding a complaint or a grievance of an applicant or a ~~recipient,~~ **member,** the following shall apply:
(1) The ~~DMHA~~ **office** may require the provider agency to correct an identified deficiency within a timeline established by the ~~DMHA.~~ **office.**
(2) A provider agency's failure to correct the deficiency within the established timeline may result in sanctions up to, and including, decertification of the provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-19; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

SECTION 230. 405 IAC 5-21.7-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-1 General provisions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 1. (a) This rule provides child mental health wraparound (CMHW) services, which are intensive, home and community-based intervention services provided according to a systems of care philosophy within a wraparound model of service delivery.

(b) The CMHW service program includes the delivery of coordinated, highly individualized wraparound services and interventions that do the following:
(1) Address the ~~participant's~~ **member's** unique needs.
(2) Build upon the strengths of the ~~participant~~ **member** and the ~~participant's~~ **member's** family or support group.
(3) Assist the ~~participant~~ **member** and the ~~participant's~~ **member's** family in achieving positive outcomes in their lives.

(c) CMHW services are provided by qualified, specially trained service providers who engage the ~~participant~~ **member** and the ~~participant's~~ **member's** family in an assessment and treatment planning process characterized by the formation of a child and family wraparound team (team).

(d) The team is developed by the ~~participant~~ **member** and family to provide the support and resources needed to assist in developing and implementing an individualized plan of care.

(e) Members of the child and family team are selected by the ~~participant~~ **member** and family and may include, but are not limited to, the following:
(1) The ~~participant~~ **member** and family who will lead the treatment planning process.
(2) The wraparound facilitator who will coordinate service delivery and assist the ~~participant~~ **member** and the ~~participant's~~ **member's** family in linking with community and natural supports.
(3) The CMHW and non-CMHW service providers, who will provide the ~~participant~~ **member** and the ~~participant's~~ **member's** family with resources and supports in the treatment process.
(4) Any individual whom the ~~participant~~ **member** and the ~~participant's~~ **member's** family select to support or assist them in implementation of the CMHW services plan of care.

(f) The CMHW services program will make available to the ~~participant~~ **member** an array of interventions, which may include, but are not limited to, the following:

(1) Behavioral health and support services.
(2) Crisis planning and intervention.
(3) Parent coaching and education.
(4) Community resources and supports.

(g) The state's purposes for providing CMHW services are to:
(1) serve eligible ~~participants~~ **members** with serious emotional disturbances; and
(2) enable them to benefit from receiving intensive wraparound services within their home and community with natural family supports.

(h) CMHW services available for eligible ~~participants~~ **members** include the following:
(1) Wraparound facilitation.
(2) Habilitation.
(3) Respite care.
(4) Training and support for unpaid caregivers.

(i) CMHW services will be administered, evaluated, and monitored by the ~~following:~~ **office.**
~~(1) The OMPP as the state Medicaid agency.~~
~~(2) The DMHA as the state operating agency.~~
~~(3) Contracted entities of the state agencies in subdivisions (1) and (2), as required to administer the CMHW services program in accordance with this rule.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-1; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 231. 405 IAC 5-21.7-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-2 Definitions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

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

(b) "Access site" means a DMHA-certified agency that will provide CMHW services applicants and families the following:
(1) Information about CMHW services and eligibility criteria.
(2) Assistance in applying for CMHW services.
(3) Linkage to the most appropriate services, based upon an applicant's identified needs.

(c) "Applicant" refers to a child who is assessed for meeting eligibility criteria for enrollment in CMHW services.

(d) "Behavioral health assessment tool" means a state designated, individually appropriate assessment tool that is:
(1) approved by the ~~DMHA;~~ **office;** and
(2) administered by a qualified individual who is trained and certified by the ~~DMHA~~ **office** to administer the tool.

(e) "Behavioral recommendation" means a recommended intensity of behavioral health services that is derived from administration of the ~~DMHA~~ **office**-approved behavioral health assessment tool, as follows:
(1) The recommendation is based on an algorithm derived from the patterns of assessment ratings, in multiple life domains, from administration of the assessment tool with the applicant or ~~participant~~ **member** and family member.
(2) This algorithm does the following:
(A) Implements the criteria for a level of need.
(B) Indicates the appropriate intensity of behavioral health services recommended for the ~~participant.~~ **member.**

(f) "Child and family wraparound team" or "team" means a wraparound treatment team or support team developed as follows:

(1) By a ~~participant~~ **member** enrolled in CMHW services and the ~~participant's~~ **member's** family.

(2) To assist a ~~participant~~ **member** and the ~~participant's~~ **member's** family in developing and implementing an individualized plan of care.

(g) "Child mental health wraparound" or "CMHW" services mean intensive, home and community-based, behavioral health wraparound services and interventions that meet the following requirements:

(1) The services are recommended by a physician or other licensed professional, within the scope of his or her practice.

(2) The services and interventions are intended for the:

(A) treatment of a mental health disability; and

(B) restoration of a ~~participant's~~ **member's** best possible functional level.

(3) The services include clinical and supportive behavioral health services provided for eligible ~~participants~~ **members** who are:

(A) living with their family in the community; and

(B) at risk of an out-of-home placement, due to their mental illness and the disruptive patterns of their behavior.

(4) The services are provided in accordance with wraparound principles and a system of care philosophy.

(h) "CMHW service provider" means a service provider or agency that:

(1) has successfully completed CMHW services provider certification and training; and

(2) meets all qualifications and standards required by the ~~OMPP and the DMHA.~~ **office.**

(i) "Corrective action" means an action imposed upon the provider by the ~~DMHA or the OMPP~~ **office** for noncompliance with CMHW services policies and procedures.

(j) "Crisis plan" means a plan of action prepared by the ~~participant,~~ **member,** the ~~participant's~~ **member's** family, and the team that specifies the following:

(1) Potential crises the ~~participant~~ **member** may experience.

(2) The planned interventions and resources available to the ~~participant~~ **member** and family to assist in deescalating a crisis situation.

(k) "DMHA" refers to the Indiana division of mental health and addiction, which is responsible for operating the CMHW services program. For purposes of this rule, use of the term "the DMHA" includes the following:

(1) Staff hired by the DMHA.

(2) An entity under contract with the DMHA to provide a service or to complete administrative tasks or functions assigned by the DMHA and required under this rule.

(l) "Eligibility determination form" means the written notice provided to the access site, documenting ~~a DMHA~~ **an office** determination regarding the meeting of eligibility for level of need and participation in the CMHW services program by an applicant or ~~participant.~~ **member.** The access site shall share this information with the applicant or ~~participant,~~ **member,** including the following information that accompanies the eligibility determination form:

(1) Approval or denial of the applicant's or ~~participant's~~ **member's** level of care or eligibility to participate in the CMHW services program.

(2) CMHW services approved or denied by the ~~DMHA.~~ **office.**

(3) The effective dates and reasons for the action or actions taken.

(4) The applicant's or ~~participant's~~ **member's** appeal and fair hearing rights and procedural information.

(m) "Family" refers to the legal guardian or caretaker responsible for the care of a ~~participant.~~ **member.**

(n) "Licensed professional" means any of the following persons:

(1) A licensed psychiatrist.

(2) A licensed physician.

(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).

(4) A licensed clinical social worker (LCSW).

(5) A licensed mental health counselor (LMHC).
(6) A licensed marriage and family therapist (LMFT).
(7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

~~(o) "OMPP" refers to the office of Medicaid policy and planning that is responsible for oversight of the CMHW services program. For purposes of this rule, the use of the term includes the following:~~
~~(1) Staff hired by the OMPP.~~
~~(2) Contract entities working on behalf of the OMPP to provide services or to complete administrative tasks or functions required under this rule.~~

~~(p) "Participant"~~ **(o) "Member"** means a person receiving CMHW services.

~~(q)~~ **(p)** "Plan of care" means the individualized treatment plan that integrates all components and aspects of care, including services that are deemed medically necessary or clinically indicated and all medical and behavioral support services and interventions needed to assist the ~~participant~~ **member** in the following:
(1) To remain in the home or community.
(2) To function at the highest level of independence possible.
(3) To achieve treatment goals.

~~(r)~~ **(q)** "Qualified professional" means a provider who is a licensed professional as defined in this subsection or supervised by a licensed professional.

~~(s)~~ **(r)** "Qualifying SED work experience" means work directly with the SED population in a way that builds functional skills, such as the following:
(1) Group counseling, one-on-one counseling, provision of skills training, or provision of therapeutic recreational activities.
(2) The provision of therapeutic foster care, or work in a capacity that may not involve mental health care, but where the work is targeted at a defined SED population.
(3) Experience in case management, therapy, or skills training, in conjunction with a mental health center is also considered as qualifying SED work experience.

~~(t)~~ **(s)** "Seriously emotionally disturbed" or "SED" refers to severe functional impairments due to a mental illness, as defined in 440 IAC 8-2-4.

~~(u)~~ **(t)** "System of care" refers to a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of children and their families, and includes the following concepts regarding care delivery:
(1) Family-driven and child-guided.
(2) Individualized and community-based.
(3) Culturally and linguistically competent.

~~(v) "The state" refers to the state agencies responsible for administration and operation of CMHW services as defined in this rule.~~

~~(w)~~ **(u)** "Unpaid caregiver" means a person, family member, neighbor, friend, co-worker, or companion who provides uncompensated care, training, guidance, companionship, or support to an enrolled CMHW services ~~participant.~~ **member.**

~~(x)~~ **(v)** "Wraparound facilitator" means an individual who facilitates and supervises the delivery of wraparound services for a CMHW services ~~participant.~~ **member.**

~~(y)~~ **(w)** "Wraparound model of service delivery" means a practice model that is a team-based process for planning and implementing formal and informal services, interventions, and supports for children with complex needs. Services are provided in a manner that is consistent with and guided by a system of care philosophy that builds on the collective action of a committed group of family, friends, community, professionals, and cross-system supports mobilizing resources and talents from a variety of sources resulting in the creation of a

plan of care that is the best fit for the family vision and story, team mission, strengths, underlying needs, resources, and strategies.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-2; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 232. 405 IAC 5-21.7-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-3 Applicants and the application process

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 3. (a) The purpose of the application process is to provide families with a means to explore whether their child may be eligible for and benefit from CMHW services.

(b) A referral application for CMHW services must be made in the manner required by the ~~OMPP and the DMHA.~~ **office.**

(c) Access sites, which are ~~DMHA~~ **office**-approved CMHW service agencies, provide a local point of access in order for applicants and their families to complete the CMHW services application process that includes the following:

(1) Completion of the CMHW services application.

(2) A face-to-face evaluation and administration of the behavioral health assessment tool to assist the ~~DMHA~~ **office** in determining whether an applicant meets the eligibility and needs-based criteria for enrollment in CMHW services.

(d) The ~~DMHA,~~ **office,** which makes the final eligibility determination for all applicants for CMHW services, shall do the following:

(1) Review the applicant's application, evaluation, and behavioral health assessment tool findings.

(2) Notify the access site regarding the ~~DMHA~~ **office** eligibility determination with an eligibility determination form.

(e) The eligibility determination form shall include the following, as applicable:

(1) Approval of the applicant for enrollment in CMHW services, if the eligibility and needs-based criteria are met.

(2) Denial of the applicant for enrollment in CMHW services if either the eligibility criteria or the needs-based criteria is not met.

(3) Initial ~~DMHA~~ **office**-approved plan of care.

(f) The access site shall do the following:

(1) Notify the family regarding the ~~DMHA~~ **office** approval or denial of the applicant for the CMHW services program.

(2) Provide the family with information regarding the family's rights, including information regarding how to appeal the ~~DMHA~~ **office** eligibility determination, if so desired.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-3; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 233. 405 IAC 5-21.7-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-4 Independent assessment and evaluation

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 4. (a) Each applicant completing the application process for CMHW services shall undergo a face-to-face assessment and evaluation by an access site.

(b) The purpose of the assessment and evaluation is to determine whether an applicant meets the CMHW services eligibility and needs-based criteria.

(c) The assessment shall include administration of the ~~DMHA~~ **office**-approved behavioral assessment tool in order to:
(1) assess an applicant's strengths, needs, and functional impairment or impairments; and
(2) assist in determining an applicant's level of need for CMHW services, based upon the assessment results and algorithm for a behavioral recommendation.

(d) The assessment or evaluation and clinical documentation gathered by the access site and submitted to the ~~DMHA~~ **office** for review and determination of an applicant's eligibility will include, but are not limited to, the following:
(1) Current and historical behavioral health needs, including treatment history and confirmation of mental health diagnoses.
(2) Evaluation findings and behavioral recommendation from administration of the ~~DMHA~~ **office**-approved behavioral assessment tool.
(3) Assessment of an applicant's functional strengths and needs.
(4) Assessment of the strengths and needs of the family.
(5) Documentation of an applicant's meeting target group and financial eligibility criteria.
(6) Documentation demonstrating that the applicant does not meet CMHW services exclusionary criteria.
(7) Information about the individual's current and historical health status and needs.
(8) Information to satisfy the state's data collection requirements.
(9) Any additional information or documentation needed to support a determination that the applicant meets eligibility and needs-based criteria required to access CMHW services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-4; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 234. 405 IAC 5-21.7-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-5 Eligibility and needs-based criteria

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 5. (a) To be enrolled in the CMHW services program, the applicant must meet the following target group eligibility criteria:
(1) The applicant meets age criteria, which is six (6) through seventeen (17) years of age.
(2) The applicant meets the criteria for two (2) or more DSM-IV-TR (or subsequent revision) diagnoses.
(3) The applicant does not meet any of the following CMHW services exclusionary criteria:
(A) Primary substance abuse disorder.
(B) Primary or secondary pervasive developmental disorder (autism spectrum disorder).
(C) Primary attention deficit hyperactivity disorder.
(D) Intellectual disability or disabilities.
(E) Dual diagnosis of serious emotional disturbance and intellectual disabilities.

(b) In addition to meeting the target group eligibility criteria, the applicant must also meet CMHW services needs-based criteria, which include the following:
(1) The applicant is experiencing significant emotional or functional impairments, or both, that impact the level of functioning at home or in the community, as a result of a mental illness, and supported by a behavioral recommendation of a 4, 5, or 6 from the administered ~~DMHA~~ **office**-approved behavioral assessment tool.
(2) The applicant that meets a 4, 5, or 6 behavioral recommendation on the behavioral assessment tool must also demonstrate dysfunctional patterns of behavior due to one (1) or more of the following behavioral or emotional needs identified on the behavioral assessment tool:
(A) Adjustment to trauma.
(B) Psychosis.
(C) Debilitating anxiety.
(D) Conduct problems.

(E) Sexual aggression.
(F) Fire-setting.

(3) The applicant demonstrates significant needs in at least one (1) of the family or caregiver areas, as indicated on the ~~DMHA~~ **office**-approved behavioral assessment tool, which results in a negative impact on the applicant's mental illness:
(A) Mental health.
(B) Supervision issues.
(C) Family stress.
(D) Substance abuse.

(4) The applicant does not meet any of the following exclusionary criteria:
(A) The applicant is at imminent risk of harm to himself or herself or to others.
(B) The applicant is identified as feasibly unable to receive intensive community-based services without compromising his or her safety, or the safety of others.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-5; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 235. 405 IAC 5-21.7-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-6 Individualized plan of care

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 6. (a) The plan of care is an individualized treatment plan that integrates all components and aspects of care, including services, interventions, and supports that are deemed medically necessary or clinically indicated.

(b) The plan of care must include all indicated medical and behavioral support services needed by a ~~participant~~ **member** in order to assist the ~~participant~~ **member** in the following:
(1) Remaining in the home or community.
(2) Functioning at the highest level of independence possible.
(3) Achieving treatment goals.

(c) The CMHW services plan of care developed within the team, with ~~participant~~ **member** and family input and inclusion, must meet the following criteria:
(1) Be developed for each ~~participant~~ **member** based upon the ~~participant's~~ **member's** unique strengths and needs, as ascertained in the evaluation or assessment.
(2) Reflect the ~~participant's~~ **member's** and the family's preferences and choices for services and providers.
(3) Contain goals that delineate the following:
(A) Clear objectives.
(B) Resources, including the child and family team member or members that will assist the ~~participant~~ **member** in meeting each goal.
(C) Service duration and frequency, based upon the ~~participant's~~ **member's** level of need and functional impairments.

(d) In addition to the plan of care, the team shall develop a crisis plan that includes the following components:
(1) Anticipated crisis or crises that the ~~participant~~ **member** may experience based upon historical information.
(2) Potential triggers that may lead to a crisis situation involving the ~~participant.~~ **member.**
(3) Interventions that have either worked or not worked in deescalating a crisis situation in the past.
(4) The plan of action for the ~~participant,~~ **member,** the ~~participant's~~ **member's** family, and members of the child and family team in the event of a crisis.
(5) Identified resources available to assist the ~~participant~~ **member** and the ~~participant's~~ **member's** family in the event of a crisis.

(e) The plan of care and the crisis plan must be submitted to the ~~DMHA~~ **office** for review and approval prior to the delivery of CMHW services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-6; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 236. 405 IAC 5-21.7-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-7 Member freedom of choice

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 7. The ~~participant~~ **member** and the ~~participant's~~ **member's** family have freedom of choice regarding the following aspects of CMHW service delivery:

(1) Determining who will participate in the team.
(2) Identifying the plan of care goals and the method for achieving those goals.
(3) Selecting the CMHW services, as supported by the ~~participant's~~ **member's** assessment and level of need that will be included in the plan of care.
(4) Choosing the ~~DMHA~~ **office**-certified CMHW service provider or providers who will provide, oversee, and monitor implementation of the plan of care.
(5) Changing the CMHW service provider or providers at any time during the ~~participant's~~ **member's** enrollment in the CMHW services program.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-7; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 237. 405 IAC 5-21.7-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-8 Eligibility period

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 8. (a) Ongoing eligibility for CMHW services is dependent upon the ~~participant~~ **member** continuing to meet eligibility and needs-based criteria for the CMHW services program.

(b) A ~~participant~~ **member** shall be eligible to receive CMHW services, as documented in the plan of care, for up to a twelve (12) month period, as long as eligibility and needs-based criteria continue to be met.

(c) Administration of the ~~DMHA~~ **office**-approved behavioral assessment tool must occur every six (6) months from the date of last administration of the tool to evaluate a ~~participant's~~ **member's** level of need and response to CMHW services.

(d) The ~~DMHA~~ **office**-approved wraparound facilitator must complete a face-to-face reevaluation of the ~~participant~~ **member** at least every twelve (12) months with input and participation from the child and family team, including the ~~participant~~ **member** and the ~~participant's~~ **member's** family.

(e) The face-to-face evaluation of the ~~participant~~ **member** shall include, but is not limited to, the following:
(1) Administration of the ~~DMHA~~ **office**-approved behavioral assessment tool to determine whether the ~~participant~~ **member** continues to meet the level of need and the needs-based criteria for CMHW services.
(2) Evaluation of the ~~participant's~~ **member's** response to CMHW services and progress towards meeting treatment goals on the plan of care.
(3) Evaluation of the ~~participant's~~ **member's** strengths, needs, and functional impairments.
(4) Documentation that the ~~participant~~ **member** continues to meet the following eligibility criteria as defined in 405 IAC 5-21.7-5:
  (A) Financial criteria.
  (B) Target group eligibility.
  (C) Needs-based criteria.
(5) The proposed updated plan of care and the crisis plan for ~~DMHA~~ **office** review and approval.

(f) The ~~DMHA~~ **office** reviews the evaluation findings to assess and determine a ~~participant's~~ **member's** continued eligibility for CMHW services.

(g) The ~~DMHA~~ **office** shall notify the wraparound facilitator regarding the results of the review determination and the ~~participant's~~ **member's** continued eligibility for services, which may include the following:

(1) Approval of the ~~participant~~ **member** for continued enrollment in CMHW services, if the ~~participant~~ **member** continues to meet CMHW services' eligibility and needs-based criteria.

(2) Denial of the ~~participant's~~ **member's** enrollment in CMHW services if the eligibility criteria or the needs-based criteria are not met.

(3) Approval of the plan of care for continued CMHW services.

(h) The wraparound facilitator shall notify the ~~participant~~ **member** and the ~~participant's~~ **member's** family regarding the ~~DMHA's~~ **office's** determination of CMHW services eligibility as follows:

(1) By providing an eligibility determination form that documents the ~~DMHA's~~ **office's** eligibility determination of approval or denial of the child for CMHW services.

(2) By providing the family with information regarding the fair hearings and appeals process.

(i) If the ~~participant~~ **member** no longer meets the level of need, or is otherwise deemed ineligible for CMHW services, the wraparound facilitator and team shall work together with the ~~participant~~ **member** and the ~~participant's~~ **member's** family to develop and implement a transition plan. The transition plan shall assist the ~~participant~~ **member** in moving from CMHW services to community-based services appropriate for the ~~participant's~~ **member's** current level of need.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-8; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 238. 405 IAC 5-21.7-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-9 Coverage requirements and limits

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 9. (a) In order for a service provider to be reimbursed for providing a CMHW service to an eligible ~~participant,~~ **member,** the service must be provided in the manner established by this section.

(b) In order to be eligible for reimbursement, a covered CMHW service shall meet the following criteria:

(1) Be documented on the ~~participant's DMHA~~ **member's office**-approved plan of care.

(2) Be supported by the ~~participant's~~ **member's** level of need, as documented in the most recent assessment of the ~~participant.~~ **member.**

(3) Be provided by ~~a DMHA~~ **an office**-certified CMHW service provider meeting all required service-specific qualifications and standards.

(4) Be provided within the scope and limitations for the service as approved by the ~~DMHA and the OMPP.~~ **office.**

(c) A CMHW service shall be deemed noncovered and shall not be eligible for reimbursement if the service meets any of the following criteria:

(1) The service is provided to the ~~participant~~ **member** at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, state, local, and private entities.

(2) The service is provided as a diversionary, leisurely, or recreational activity that is not a component of respite care service.

(3) The service is provided in a manner that is not within the scope or limitations of the CMHW service.

(4) The service is not documented as a covered or authorized service on the participant's ~~DMHA~~ **office**-approved plan of care.

(5) Provision of the service is not supported by the ~~DMHA~~ **office**-approved documentation standards in the ~~participant's~~ **member's** clinical record.

(6) The service is provided by a service provider other than the service provider documented on the ~~participant's~~ **member's** plan of care.

(7) The service provided exceeds the limits approved by ~~DMHA,~~ **the office,** including the quantity, limit, duration, or frequency of the service.

(8) The service is listed in this rule as a noncovered service or is otherwise excluded from coverage.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-9; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 239. 405 IAC 5-21.7-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-10 Provider certification and application process

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 10. (a) Only ~~a DMHA~~ **an office**-certified individual or agency enrolled as a ~~Medicaid~~ provider of CMHW services may be reimbursed for providing a CMHW service to an eligible ~~participant.~~ **member.**

(b) A CMHW service provider must be authorized by the ~~DMHA~~ **office** according to the specific qualifications for and standards of the service that the provider or agency is eligible to provide, as further defined in section 11 of this rule.

(c) ~~A DMHA~~ **An office**-authorized service provider must be classified as one (1) of the following types of CMHW service provider:

(1) An accredited agency provider, which is defined as a provider employed by an accredited agency meeting the following requirements:

(A) The provider is authorized by the ~~DMHA~~ **office** as a community mental health center (CMHC) or has been accredited by one (1) of the following nationally recognized accrediting bodies:

(i) The Accreditation Association for Ambulatory Health Care (AAAHC).
(ii) The American Council for Accredited Certification (ACAC).
(iii) The Commission on Accreditation of Rehabilitation Facilities (CARF).
(iv) The Council on Accreditation (COA).
(v) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
(vi) The National Committee for Quality Assurance (NCQA).
(vii) The Utilization Review Accreditation Commission (URAC).

(B) The agency participates in a local system of care, which includes both a governing coalition and a service delivery system that endorses the values and principles of wraparound services, or, if that area of the state does not have an organized system of care, the provider is a part of a DMHA-authorized access site for services.

(C) The agency has employed a provider or providers that qualify to provide one (1) or more CMHW service, as set out in section 11 of this rule.

(2) A nonaccredited agency provider is defined as a provider employed by an agency without accreditation from a nationally-recognized accrediting body that meets the following requirements:

(A) The agency is able to submit documentation proving that the agency has articles of incorporation.

(B) The agency has employed a provider or providers that qualify to provide one (1) or more CMHW services, as defined in section 11 of this rule.

(3) An individual service provider is defined as a licensed or unlicensed service provider that meets the following requirements:

(A) The individual provider is not employed by an accredited or nonaccredited agency as defined in this section.

(B) The individual provider qualifies to deliver one (1) or more CMHW services, as defined in section 11 of this rule.

(d) An agency or individual provider that requests enrollment as a CMHW service provider must complete the following application requirements:

(1) Complete and submit the CMHW service provider application to the ~~DMHA~~ **office** for review and consideration.

(2) Submit documentation demonstrating that the individual or agency meets all qualifications outlined in this subsection.

(3) Submit documentation demonstrating that an individual provider or a provider hired by an accredited or nonaccredited agency meets the qualifications for the CMHW service certification that is being applied for, as defined in section 11 of this rule.

(4) Submit documentation demonstrating completion of the following screenings required of all providers:

(A) Fingerprinting based on national and state criminal history background screenings.
(B) Local law enforcement screening.
(C) State and local department of child services abuse registry screening.
(D) A five-panel drug screening or, in the alternative, the provider meets the requirements specified under the Federal Drug Free Workplace Act of 1988 (P.L.100-690, Title V, subtitle D).

(e) The ~~DMHA~~ **office** shall review the provider application and documentation to determine whether the agency or the individual meets the criteria for ~~a DMHA~~ **an office**-authorized CMHW service provider.

(f) An individual or an agency meeting the criteria as a CMHW service provider and receiving ~~a DMHA~~ **an office** certification approval letter must also apply to the ~~OMPP~~ **office** for a Medicaid Indiana Health Coverage Programs (IHCP) provider number prior to providing and billing for CMHW services.

(g) If the ~~OMPP~~ **office** denies the request of an individual or an agency for an IHCP provider number, then the individual or the agency will not be authorized to:
(1) provide;
(2) bill for; or
(3) be reimbursed for;
any CMHW service.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-10; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 240. 405 IAC 5-21.7-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-11 Provider authorization and service provider qualifications

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-17-12; IC 12-17.2-4; IC 12-17.2-5; IC 12-29; IC 25-23.6; IC 25-27.5-5; IC 25-33-1; IC 31-27-3; IC 31-27-4

Sec. 11. (a) In addition to meeting CMHW service standards required for the provider authorization process, as defined in section 10 of this rule, the service provider must also meet service-specific qualifications, based upon the specific CMHW service for which the provider is seeking ~~DMHA~~ **office** authorization to deliver.

(b) A wraparound facilitation service provider must meet the following qualifications and standards:
(1) The provider must be employed by ~~a DMHA~~ **an office**-authorized accredited agency.
(2) The provider must qualify as an other behavioral health professional (OBHP), as defined in 405 IAC 5-21.5-1, who has one (1) of the following:
(A) A bachelor's degree with two (2) or more years of clinical experience.
(B) A master's degree in social work, psychology, counseling, nursing, or other mental health-related field, with two (2) or more years of clinical experience.
(3) The provider must complete the following ~~DMHA~~ **office**-required service provider training and certifications:
(A) CMHW services orientation.
(B) Child and adolescent needs and strengths assessment tool certification.
(C) Wraparound practitioner certification, provided, however, that the facilitator shall have eighteen (18) months after the starting date to complete the certification.
(D) Cardiopulmonary resuscitation (CPR) certification.

(c) A habilitation service provider must meet the following qualifications and standards:
(1) Be at least twenty-one (21) years of age.
(2) Possess a high school diploma or the equivalent.
(3) Demonstrate a minimum of three (3) years of qualifying SED work experience.
(4) Provide documentation of a safe driving record, as well as the following:
(A) A current driver's license.
(B) Proof of motor vehicle insurance coverage.
(C) Proof of current vehicle registration.
(5) For every thirty (30) hours of habilitation services provided, the provider must obtain one (1) hour of face-to-face supervision with an approved mental health service provider that meets one (1) of the following

licensure requirements:
(A) Licensure in psychology (HSPP) as defined in IC 25-33-1.
(B) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8.
(C) Licensed clinical social worker (LCSW) under IC 25-23.6-5.
(D) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5.
(6) Complete the following ~~DMHA~~ **office**-required service provider training:
(A) CMHW services orientation.
(B) CPR certification.

(d) A CMHW respite care service provider must meet the following requirements and standards as applicable:
(1) All individuals providing respite care services must meet the following qualifications and standards:
(A) Be at least twenty-one (21) years of age.
(B) Possess a high school diploma or the equivalent.
(C) Demonstrate three (3) years of qualifying SED work experience.
(D) Provide documentation of a safe driving record, as well as:
(i) a current driver's license;
(ii) proof of motor vehicle insurance coverage; and
(iii) proof of current vehicle registration.
(E) Complete the following ~~DMHA~~ **office**-required service provider training:
(i) CMHW services orientation.
(ii) CPR certification.
(2) A ~~participant's~~ **member's** relative, related by blood, marriage, or adoption, who is not the ~~participant's~~ **member's** legal guardian or primary caregiver and who does not live in the ~~participant's~~ **member's** home, may also provide respite care services, under the following conditions:
(A) The individual is selected by the ~~participant~~ **member** or the ~~participant's~~ **member's** family to provide the service.
(B) The team has determined that provision of the service by a relative is in the best interests of the ~~participant.~~ **member.**
(C) The individual providing the service must do the following:
(i) Apply for and be certified as a CMHW respite care service provider.
(ii) Meet all of the qualifications and standards required for an individual respite care service provider.
(3) ~~DMHA~~ **Office**-authorized respite care service providers may include the following agencies or facilities licensed by the ~~Indiana family and social services administration, division of family resources,~~ **office** or the Indiana department of child services, and shall meet CMHW services accredited agency certification standards defined in section 10 of this rule:
(A) Emergency shelters licensed under 465 IAC 2-10.
(B) Foster homes licensed under IC 31-27-4, including special needs and therapeutic foster homes only when the licensed child placing agency (LCPA) is ~~a DMHA~~ **an office**-certified agency provider. The ~~DMHA~~ **office** is authorized to request a copy of the study of the home of the foster parent providing respite care services.
(C) Other child caring institutions licensed under IC 31-27-3.
(D) Child care centers licensed under IC 12-17.2-4.
(E) Child care homes licensed under IC 12-17.2-5.
(F) School age child care project licensed under IC 12-17-12.

(e) A CMHW services training and support for unpaid caregiver service provider must meet the following qualifications and standards:
(1) Be at least twenty-one (21) years of age.
(2) Possess a high school diploma or the equivalent.
(3) Demonstrate two (2) years of qualifying SED work experience with SED children.
(4) With regard to an individual service provider, live within a one-county area from the county of the ~~participant's~~ **member's** residence.
(5) Complete the following ~~DMHA~~ **office**-required service provider training:
(A) CMHW service orientation.
(B) CPR certification.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-11; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 241. 405 IAC 5-21.7-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-12 Provider training

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 12. (a) Each year ~~a DMHA~~ **an office-**authorized CMHW service provider must complete ten (10) hours of ongoing training and continuing education in either child mental health or SED child-related topics.

(b) The provider must keep current all service-related trainings and certifications required for a CMHW service provider.

(c) The provider must submit verification of compliance with training and service-related certification requirements to the ~~DMHA~~ **office** at the time of provider reauthorization.

(d) A service provider's failure to comply with CMHW training and service-related certification requirements may result in the revocation of the provider's CMHW service provider authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-12; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 242. 405 IAC 5-21.7-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-13 Provider reauthorization

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 13. (a) To ensure continued compliance with provider qualifications and standards for providing CMHW services, ~~a DMHA~~ **an office**-certified CMHW service provider must reapply for certification according to the following recertification schedule:

(1) An accredited agency provider must apply for recertification:
  (A) at least every three (3) years following the initial DMHA certification; or
  (B) at the time of the agency reaccreditation;
whichever date is earlier.

(2) A nonaccredited agency provider must apply for reauthorization at least every two (2) years following the initial ~~DMHA~~ **office** authorization.

(3) An individual service provider must apply for reauthorization at least every two (2) years following the initial DMHA certification.

(b) A provider must submit the application for reauthorization in writing to the ~~DMHA~~ **office** at least sixty (60) days prior to the due date for reauthorization.

(c) An agency or individual provider applying for reauthorization as a CMHW service provider must complete the following application requirements:

(1) Complete and submit the CMHW services provider recertification application to the ~~DMHA~~ **office** for review and consideration.

(2) Submit documentation demonstrating that the individual provider or agency provider continues to meet all qualifications contained in section 10 of this rule.

(3) Submit documentation demonstrating that the individual provider or agency provider continues to meet the qualifications for the CMHW service authorization being applied for, as defined in section 11 of this rule.

(4) Submit documentation demonstrating compliance with the following:
  (A) Yearly provider continuing education training.
  (B) Updated certification requirements.

(d) The ~~DMHA~~ **office** shall review the provider application and documentation to determine whether the agency or individual provider continues to meet the criteria for authorization as a CMHW service provider.

(e) Failure to comply with authorization requirements in a timely manner will result in the following corrective action:

(1) The agency or individual provider will be placed on suspended status as a CMHW services provider, pending the completion of the ~~DMHA~~ **office** reauthorization process.

(2) The agency or individual provider must continue to provide services to those ~~participants~~ **members** whom the provider is currently serving, but will be prohibited from accepting any new ~~participants.~~ **members.**

(3) Upon the ~~DMHA's~~ **office's** receipt and approval of the provider reauthorization paperwork, the status of the agency or individual provider will be updated to active status, thereby allowing the provider to accept new CMHW services ~~participants.~~ **members.**

(4) A provider's continued failure to comply with reauthorization requirements will result in the ~~DMHA's~~ **office's** revoking authorization for that provider to deliver CMHW services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-13; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 243. 405 IAC 5-21.7-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-14 Provider sanctions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 14. (a) Under 405 IAC 1-1-6, if a provider has violated any provision established under IC 12-15, the ~~OMPP~~ **office** may impose one (1) or more of the following sanctions:

(1) Deny payment.
(2) Revoke authorization as a CMHW services provider.
(3) Assess a fine.
(4) Assess an interest charge.
(5) Require corrective action against an agency or a provider.

(b) The loss of ~~DMHA~~ **office** authorization for a provider to deliver CMHW services may occur due to, but not limited to, the following:

(1) The provider's failure to adhere to and follow CMHW services policies and procedures for behavior, documentation, billing, or service delivery.

(2) The provider's failure to respond to or resolve a corrective action imposed upon the provider by the ~~DMHA or the OMPP~~ **office** for noncompliance with CMHW services' policies and procedures.

(3) The provider's failure to maintain CMHW services provider qualifications, ~~DMHA~~ **office**-required training, or standards contained in this rule for the CMHW service or services the provider is authorized to provide.

(4) The provider's failure to timely reapply for CMHW services provider authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-14; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 244. 405 IAC 5-21.7-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-15 Services: general provisions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 15. (a) All CMHW services provided to a ~~participant~~ **member** must meet the following requirements:

(1) Be supported by the ~~participant's~~ **member's** level of need.

(2) Be documented in the ~~participant's~~ **member's** plan of care.

(b) A provider shall maintain documentation for services provided to a CMHW services ~~participant~~ **member** in accordance with the requirements under 405 IAC 1-5-1.

(c) Provider reimbursement for CMHW services is subject to, but not limited to, the following:

(1) The ~~participant's~~ **member's** eligibility for services.

(2) The provider's qualifications and certification.
(3) Prior authorization by the ~~DMHA.~~ **office.**
(4) The scope, limitations, and exclusions of the services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-15; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 245. 405 IAC 5-21.7-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-16 Wraparound facilitation services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 16. (a) Wraparound facilitation services are as follows:
(1) Comprehensive services comprised of a variety of specific tasks and activities designed to carry out the wraparound process.
(2) A required component of the CMHW services program.

(b) Wraparound facilitation is:
(1) a planning process that follows a series of steps; and
(2) provided through a child and family wraparound team.

(c) The team is responsible for assuring that a ~~participant's~~ **member's** needs, and the entities responsible for addressing those needs, are identified in a written plan of care.

(d) The wraparound facilitator manages and supervises the wraparound process through the following activities:
(1) Completing a comprehensive evaluation of the ~~participant,~~ **member,** including administration of the ~~DMHA~~ **office**-approved behavioral assessment tool.
(2) Guiding the family engagement process by exploring and assessing strengths and needs.
(3) Facilitating, coordinating, and attending team meetings.
(4) Working in full partnership with the ~~participant,~~ **member,** family, and team members to ensure that the plan of care is developed, written, and approved by the ~~DMHA.~~ **office.**
(5) Assisting the ~~participant~~ **member** and the ~~participant's~~ **member's** family in gaining access to the full array of services, that is, medical, social, educational, or other needed services.
(6) Guiding the planning process for the plan of care by:
(A) informing the team of the family's vision; and
(B) ensuring that the family's vision is central to the planning and delivery of services.
(7) Ensuring the development, implementation, and monitoring of a crisis plan.
(8) Assuring that all work to be done to assist the ~~participant~~ **member** and the ~~participant's~~ **member's** family in achieving goals on the plan of care is identified and assigned to a team member.
(9) Overseeing and monitoring all services authorized for a ~~participant's~~ **member's** plan of care.
(10) Reevaluating and updating the plan of care as dictated by the ~~participant's~~ **member's** needs and securing ~~DMHA~~ **office** approval of the plan of care.
(11) Assuring that care is delivered in a manner consistent with strength-based, family-driven, and culturally competent values.
(12) Offering consultation and education to all CMHW service providers regarding the values and principles of the wraparound services model.
(13) Monitoring a ~~participant's~~ **member's** progress toward meeting treatment goals.
(14) Ensuring that necessary data for evaluation is gathered, recorded, and preserved.
(15) Ensuring that the CMHW services assessment and service-related documentation are gathered and reported to the ~~DMHA~~ **office** as required by the ~~DMHA.~~ **office.**
(16) Completing an annual CMHW services level of need reevaluation, with active involvement of the ~~participant,~~ **member,** the ~~participant's~~ **member's** family, and the team.
(17) Guiding the transition of the ~~participant~~ **member** and the ~~participant's~~ **member's** family from CMHW services to state plan services or other community-based services when indicated.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-16; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 246. 405 IAC 5-21.7-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-17 Habilitation services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 17. (a) Habilitation services are provided with the following goals:
(1) Enhancing the ~~participant's~~ **member's** level of functioning, quality of life, and use of social skills.
(2) Building the strengths, resilience, and positive outcomes of the ~~participant~~ **member** and the ~~participant's~~ **member's** family.

(b) Habilitation services are provided face-to-face in either the ~~participant's~~ **member's** home or other community-based setting, based upon the preferences of the ~~participant~~ **member** and the ~~participant's~~ **member's** family.

(c) Habilitation services are provided to assist the ~~participant~~ **member** with the following:
(1) Identifying feelings.
(2) Managing anger and emotions.
(3) Giving and receiving feedback, criticism, or praise.
(4) Problem solving and decision making.
(5) Learning to resist negative peer pressure and develop pro-social peer interactions.
(6) Improving communication skills.
(7) Building and promoting positive coping skills.
(8) Learning how to have positive interactions with peers and adults.

(d) Service exclusions are the following:
(1) Services provided to a person other than the ~~participant,~~ **member,** such as when an activity occurs in a group setting.
(2) Services provided to a family member or members.
(3) Services provided in order to give the family respite.
(4) Services that are strictly vocational or educational in nature, such as tutoring or any other activity available to the ~~participant~~ **member** through the local educational agency under the:
(A) Individuals with Disabilities Education Improvement Act of 2004; or
(B) Rehabilitation Act of 1973.
(5) Activities provided in the service provider's residence.
(6) Leisure activities that provide a diversion rather than a therapeutic objective.

(e) The provision of habilitation services is limited to the following:
(1) Up to three (3) hours of services daily.
(2) Up to thirty (30) hours of services per month.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-17; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 247. 405 IAC 5-21.7-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-18 Respite care services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 18. (a) Respite care services are:
(1) provided to a ~~participant~~ **member** unable to care for himself or herself; and
(2) furnished on a short-term basis because of the absence, or need for relief, of a person or persons who normally provide care for the ~~participant.~~ **member.**

(b) Respite care services may be provided in the following manner for planned or routine time frames when a

caregiver is aware of needing relief or assistance through respite care:
(1) On an hourly basis, but billed for less than seven (7) hours in the same day.
(2) On a daily basis and billed for a service provided from seven (7) to twenty-four (24) hours in the same day.
(3) As a daily service not to exceed a period of fourteen (14) consecutive days at one (1) time.

(c) Crisis respite care services may be provided on an unplanned basis when the caregiver requires assistance in caring for a ~~participant~~ **member** as follows:
(1) In a crisis situation in which a child's health and welfare would be seriously impacted or harmed in the absence of crisis respite care.
(2) On a daily basis, and billed from eight (8) to twenty-four (24) hours in the same day.
(3) Not to exceed fourteen (14) consecutive days at one (1) time.

(d) Respite care services must be provided in the least restrictive environment available to ensure the health and welfare of the ~~participant.~~ **member.**

(e) Respite care service may be provided in the following locations:
(1) The ~~participant's~~ **member's** home or private place of residence in the community.
(2) Any ~~DMHA~~ **office**-certified state licensed facility.

(f) A ~~participant~~ **member** who needs consistent twenty-four (24) hour supervision, with regular monitoring of medications or behavioral symptoms, must be placed in a facility under the supervision of any of the following:
(1) A psychologist.
(2) A psychiatrist, physician, or nurse who meets licensing or certification requirements of his or her profession in the state of Indiana.

(g) Allowed respite care service activities include the following:
(1) Assistance with daily living skills, including assistance with accessing community activities and transporting the ~~participant~~ **member** to or from community activities.
(2) Assistance with grooming and personal hygiene.
(3) Meal preparation, serving, and cleanup.
(4) The administration of medications.
(5) Supervision.

(h) Respite care service exclusions are the following:
(1) Respite care provided by the following:
(A) A parent or parents for a ~~participant~~ **member** who is a minor child.
(B) Any relative who is the primary caregiver of a ~~participant.~~ **member.**
(C) Any individual living in a ~~participant's~~ **member's** residence.
(2) Respite care services provided as a substitute for regular child care to allow the parent to attend school or to engage in employment or employment search-related activities.
(3) Respite care provided in the residence of a CMHW respite care service provider, unless the service is provided by ~~a DMHA~~ **an office**-authorized relative of the ~~participant.~~ **member.**
(4) Respite care used to provide services to the ~~participant~~ **member** while the ~~participant~~ **member** is attending school.
(5) Crisis respite care service scheduled to relieve the family when a ~~participant~~ **member** is in crisis.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-18; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 248. 405 IAC 5-21.7-19 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-19 Training and support for unpaid caregiver services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 19. (a) Training and support for unpaid caregivers is a service for an individual who is providing unpaid support, training, companionship, or supervision for a ~~participant.~~ **member.**

(b) The intent of this service is to provide education and supports to assist the caregiver in preserving the ~~participant's~~ **member's** family unit.

(c) Training and support activities must be:
(1) based on the unique needs of the family and caregiver; and
(2) identified in the plan of care.

(d) The providers of training and support activities must be identified in the plan of care.

(e) Allowed training and support activities for a caregiver may include, but are not limited to, the following:
(1) Practical living and decision making skills.
(2) Child development and parenting skills.
(3) Home management skills.
(4) Use of community resources and development of informal supports.
(5) Conflict resolution skills.
(6) Coping skills.
(7) Assistance in increasing understanding of a ~~participant's~~ **member's** mental health needs.
(8) Teaching communication and crisis deescalation skills geared for working with ~~participant's~~ **member's** mental health and behavioral needs.

(f) Nonhourly training and support service must be provided according to the following requirements:
(1) The service provides reimbursement to cover the costs for a training event or training resources, such as registration or conference fees, books, or supplies associated with the identified training and support need.
(2) A training support need must be as follows:
(A) Identified by the team as a ~~participant's~~ **member's** need.
(B) Documented on the ~~participant's~~ **member's** plan of care.
(3) An approved event identified by the team must be provided by one (1) of the following types of ~~DMHA~~ **office**-approved resources:
(A) A nonprofit, civic, faith-based, professional, commercial, or government agency or organization.
(B) A community college, vocational school, or university.
(C) A lecture series, workshop, conference, or seminar.
(D) An online training program.
(E) A community mental health center.
(F) Other qualified community service agency.
(4) The maximum annual limitation for a nonhourly service is five hundred dollars ($500).

(g) The hourly training and support service is provided in the following manner:
(1) The service is provided for the caregiver identified on the plan of care.
(2) The service is provided face-to-face in the home or a community-based setting.
(3) An hourly service is limited to a maximum of two (2) hours per day.
(4) There is no annual limit for the hourly service subject, however, to the limitation in subdivision (3).

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-19; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 249. 405 IAC 5-21.7-20 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-20 Fair hearings and appeals

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 20. (a) CMHW services applicants, ~~participants,~~ **members,** and their families shall have an opportunity to request a fair hearing to appeal a decision of the ~~DMHA~~ **office** regarding CMHW services eligibility or a request for services as described in this section.

(b) Information concerning a ~~participant's~~ **member's** right to a fair hearing and appeal and how to request such

an appeal's hearing shall be provided to an applicant, ~~participant,~~ **member,** or the family of an applicant or ~~participant~~ **member** at the following times:

(1) Provided to the applicant and the applicant's family by the local access site following the ~~DMHA's~~ **office's** determination of the applicant's eligibility for CMHW services.

(2) Provided to the ~~participant~~ **member** and family by the wraparound facilitator following the ~~DMHA~~ **office** review of a proposed CMHW services plan of care, or updated plan of care, to document the ~~DMHA~~ **office** authorization or denial of the requested CMHW services.

(3) Provided to the ~~participant~~ **member** and family by the wraparound facilitator following the ~~participant's~~ **member's** reevaluation for CMHW services eligibility.

(c) Notices of adverse action and the opportunity for a fair hearing shall be maintained in the ~~participant's~~ **member's** record by the local wraparound facilitation agency and by the ~~DMHA.~~ **office.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-20; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 250. 405 IAC 5-21.7-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-21 Complaints and grievances

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 21. (a) An applicant, a ~~participant,~~ **member,** and the family of an applicant or a ~~participant~~ **member** shall have the right to file a complaint or grievance in writing with the state regarding CMHW service providers or CMHW services. All complaints and grievances are accepted by the following means:

(1) Delivery to the family-consumer section on the DMHA website.

(2) Delivery in-person to a DMHA staff member.

(3) Delivery via written complaint or e-mail that is submitted to the DMHA.

(b) The receipt of a complaint or grievance shall be recorded in the ~~DMHA's~~ **office's** data system with a copy attached to the provider's file. An investigation shall begin within seventy-two (72) hours of receipt of the complaint or grievance.

(c) When an investigation is complete, the following shall occur:

(1) The individual filing the complaint or grievance shall be informed of the ~~DMHA's~~ **office's** investigative findings through a letter from ~~a DMHA~~ **an office** staff member.

(2) The individual who filed a grievance or complaint must be informed that filing a grievance or complaint is neither a prerequisite nor a substitute for a fair hearing.

(d) If indicated by the results of an investigation, a letter of findings shall be sent to the CMHW service provider who is the subject of the complaint or grievance. The CMHW service provider shall correct any identified deficiency within the timeline established by the ~~DMHA.~~ **office.**

(e) If the CMHW service provider fails to correct the deficiency within the established timeline, the ~~DMHA~~ **office** may pursue sanctions up to, and including, revoking authorization for the provider to deliver CMHW services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-21; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA)

SECTION 251. 405 IAC 5-21.8-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-2 Definitions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

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

(b) "Applicant" refers to an individual who is seeking enrollment in BPHC services.

(c) "Behavioral and primary health care coordination services" or "BPHC services" refers to coordination of health care services to manage the health care needs of the ~~recipient~~ **member** including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services.

(d) "Certified community health worker" or "CHW" refers to an individual who meets all of the following:
(1) Has completed the CHW ~~DMHA~~ **office** and Indiana state department of health state-approved training program.
(2) Receives a passing score on the certification exam.
(3) Is supervised by a licensed professional or QBHP.
(4) Delivers services as defined at section 8(a) of this rule.

(e) "Certified recovery specialist" or "CRS" refers to an individual who meets all of the following:
(1) Is maintaining healthy recovery from mental illness.
(2) Has completed the CRS ~~DMHA~~ **office** state-approved training program.
(3) Receives a passing score on the certification exam.
(4) Is supervised by a licensed professional or QBHP.
(5) Delivers services as defined at section 8(a) of this rule.

~~(f) "Division of mental health and addiction approved behavioral health assessment tool" means the state designated assessment tool administered by a qualified individual who is trained and DMHA-certified to administer the tool in order to assist in determining the level of need and functional impairment of an applicant or a recipient.~~

~~(g)~~ **(f)** "DMHA" means the division of mental health and addiction.

~~(h)~~ **(g)** "Health" means physical and behavioral health.

~~(i)~~ **(h)** "Individualized integrated care plan" or "IICP" means a treatment plan that meets all of the following:
(1) Integrates all components and aspects of care that are:
  (A) deemed medically necessary;
  (B) needs-based;
  (C) clinically indicated; and
  (D) provided in the most appropriate setting to achieve the ~~recipient's~~ **member's** goals.
(2) Includes all indicated medical and support services needed by the ~~recipient~~ **member** in order to:
  (A) remain in the community;
  (B) function at the highest level of independence possible; and
  (C) achieve goals identified in the IICP.
(3) Reflects the ~~recipient's~~ **member's** desires and choices.

~~(j)~~ **(i)** "Level of need" means a recommended intensity of services based on a pattern of a ~~recipient's~~ **member's** needs, as determined using the ~~DMHA~~ **office**-approved behavioral health assessment tool.

~~(k)~~ **(j)** "Licensed professional" means any of the following persons:
(1) A licensed psychiatrist.
(2) A licensed physician.
(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
(4) A licensed clinical social worker (LCSW).
(5) A licensed mental health counselor (LMHC).
(6) A licensed marriage and family therapist (LMFT).
(7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

~~(l)~~ **(k)** "Medicaid rehabilitation services" means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of that individual's practice under state law, for:

(1) maximum reduction of physical or mental health disability; and

(2) restoration to a ~~recipient's~~ **member's** best possible level of functioning.

(l) "Member" means a person receiving BPHC services.

(m) "Needs-based eligibility criteria" means factors used to determine an applicant's need for BPHC services. The applicant meets the BPHC needs-based eligibility criteria when the following are demonstrated:

(1) Needs related to management of the applicant's health.

(2) Impairment in self-management of the applicant's health services.

(3) A health need that requires assistance and support in coordinating health treatment.

(4) A recommendation for intensive community based care based on the uniform ~~DMHA~~ **office-**approved behavioral health assessment tool as indicated by a rating of three (3) or higher.

~~(n) "Office" refers to the office of Medicaid policy and planning.~~

(n) "Office-approved behavioral health assessment tool" means the state designated assessment tool administered by a qualified individual who is trained and office-certified to administer the tool in order to assist in determining the level of need and functional impairment of an applicant or a member.

(o) "Other behavioral health professional" or "OBHP" means any of the following:

(1) An individual with an associate's or bachelor's degree, or equivalent behavioral health experience who:

(A) meets minimum competency standards set forth by a behavioral health service provider; and

(B) is supervised by either a licensed professional or a QBHP.

(2) A licensed addiction counselor, as defined under IC 25-23.6-10.5, who is supervised by either a licensed professional or a QBHP.

(p) "Provider agency" means any ~~DMHA~~ **office**-approved agency that meets the qualifications and criteria to become a BPHC provider agency, as required by this rule.

(q) "Provider staff" means any individual working for ~~a DMHA~~ **an office**-approved BPHC provider agency who meets the qualifications and requirements mandated by the BPHC service being provided, as defined in this rule.

(r) "Qualified behavioral health professional" or "QBHP" means any of the following:

(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master's degree or a doctoral degree, or both, in any of the following disciplines from an accredited university:

(A) Psychiatric or mental health nursing, including a license as a registered nurse in Indiana.

(B) Pastoral counseling.

(C) Rehabilitation counseling.

(2) An individual who:

(A) is supervised by a licensed professional;

(B) is eligible for and working toward professional licensure; and

(C) has completed a master's degree or a doctoral degree, or both, in any of the following disciplines from an accredited university:

(i) Social work from a university accredited by the Council on Social Work Education.

(ii) Psychology.

(iii) Mental health counseling.

(iv) Marital and family therapy.

(3) A licensed, independent practice school psychologist under the supervision of a licensed professional.

(4) An authorized health care professional (AHCP) who is either of the following:

(A) A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.

(B) A nurse practitioner or clinical nurse specialist, with prescriptive authority, performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a

licensed physician under IC 25-23-1.

~~(s) "Recipient" means a person receiving BPHC services.~~

~~(t)~~ **(s)** "State evaluation team" means the ~~DMHA~~ **office** independent evaluation team that will review and assess all evaluation information and supporting clinical documentation collected for BPHC applicants and ~~recipients~~ **members** and will be responsible for making final determinations regarding the following:
(1) Needs-based and target group eligibility of applicants for BPHC services.
(2) Authorization for BPHC services for eligible ~~recipients.~~ **members.**
(3) Continued eligibility determination for BPHC ~~recipients.~~ **members.**
(4) Appropriate service delivery to BPHC ~~recipients~~ **members** as a result of conducting quality improvement reviews of BPHC service provider agencies.

~~(u)~~ **(t)** "Target group eligibility criteria" means factors used to determine an applicant's eligibility for BPHC services. To meet the BPHC target group criteria, an applicant must:
(1) be nineteen (19) years of age or older; and
(2) have been diagnosed with an eligible primary mental health diagnosis as defined at section 4(3) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-2; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 252. 405 IAC 5-21.8-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-3 Applicants and the application process

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 3. (a) In order for an individual to receive services under this rule, a BPHC eligible provider agency, in collaboration with the applicant, must submit an application in the manner required by the office. ~~and the DMHA.~~

(b) Each applicant for BPHC services must receive a face-to-face evaluation using both the:
(1) ~~DMHA~~ **office**-approved behavioral health assessment tool; and
(2) application form developed by the office. ~~and DMHA.~~

(c) The application form and supporting documentation should include the following information about the applicant:
(1) Health status.
(2) Current living situation.
(3) Family functioning.
(4) Vocational or employment status.
(5) Social functioning.
(6) Living skills.
(7) Self-care skills.
(8) Capacity for decision making.
(9) Potential for self-injury or harm to others.
(10) Substance use or abuse.
(11) Need for assistance managing a medical condition.
(12) Medication adherence.

(d) An application must, at a minimum, include documentation demonstrating the following:
(1) The applicant is an active ~~participant~~ **member** in the planning and development of the IICP.
(2) The applicant is requesting the services listed on the proposed IICP submitted with the application.
(3) The applicant has chosen, from a randomized list of eligible BPHC service providers in the applicant's community, a provider to deliver the ~~DMHA~~ **office** authorized BPHC services under this rule.

(e) Upon receipt of the application and supporting clinical documentation, the ~~DMHA~~ state evaluation team will

assess the submitted information and determine whether or not the applicant meets the needs-based and target group eligibility criteria for receiving BPHC services.

(f) For those applicants who are not Medicaid enrolled at the time of application for BPHC services, a Medicaid application must be submitted in the manner set forth in 405 IAC 2-1.1 for a Medicaid eligibility determination.

(g) The ~~DMHA~~ state evaluation team retains responsibility for the following:
(1) Determining whether an applicant meets the needs-based and target group eligibility criteria for BPHC services.
(2) Approving all proposed BPHC services included in the IICP.

(h) Any approval or denial of eligibility for services under this rule will be communicated to the:
(1) applicant or the applicant's authorized representative; and
(2) referring provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-3; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 253. 405 IAC 5-21.8-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-4 Eligibility

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 4. To be eligible for services under this rule, an applicant must meet all of the following:
(1) All of the criteria set forth in 405 IAC 2-1.1-6.
(2) Be nineteen (19) years of age or older.
(3) The applicant has been diagnosed with a BPHC-eligible primary mental health diagnosis including, but not limited to:
  (A) schizophrenic disorder;
  (B) major depressive disorder;
  (C) bipolar disorder;
  (D) delusional disorder; or
  (E) psychotic disorder.
(4) The applicant either:
  (A) resides in a community-based setting that is not an institutional setting; or
  (B) will be discharged from an institutional setting back to a community-based setting.
(5) The applicant meets all of the following needs-based eligibility criteria, as defined in section 2(m) of this rule, based on the following:
  (A) Behavioral health clinical evaluation.
  (B) Referral form.
  (C) Supporting documentation.
  (D) The ~~DMHA~~ **office** behavioral health assessment tool results.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-4; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 254. 405 IAC 5-21.8-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-5 IICP authorization period; renewal

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 5. (a) A ~~recipient~~ **member** approved to receive BPHC services under this rule shall be eligible for such services for up to a six (6) month period commencing from the date of service approval and authorization, as long as eligibility and needs-based eligibility criteria and other eligibility continue to be met.

(b) A reevaluation will be conducted at least every six (6) months and shall include the following:
(1) Conducting a face-to-face holistic clinical and biopsychosocial evaluation completed by ~~a DMHA~~ **an office**-approved BPHC service provider.
(2) Administering the ~~DMHA~~ **office**-approved behavioral assessment tool to determine whether the ~~recipient~~ **member** still meets the level of need for intensive community-based services, as demonstrated by a rating level of three (3) or higher.
(3) Assessing the ~~recipient's~~ **member's** progress toward meeting treatment goals set forth in the IICP.
(4) Documenting that the ~~recipient~~ **member** continues to meet BPHC target group eligibility and needs-based eligibility criteria.
(5) Completing an updated application.
(6) Completing an updated IICP documenting the ~~recipient's~~ **member's** choice of BPHC service providers.

(c) The ~~DMHA~~ **state** evaluation team will review and assess the application and reevaluation results to determine whether the ~~recipient~~ **member** continues to meet needs-based and target group eligibility criteria.

(d) Any approval or denial of eligibility and services under this rule will be communicated to the following:
(1) The applicant or the applicant's authorized representative.
(2) The referring provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-5; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 255. 405 IAC 5-21.8-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-6 Clinical documentation requirements

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 6. (a) To be reimbursable under this rule, the BPHC service must be supported by clinical documentation that is maintained in the ~~recipient's~~ **member's** clinical record.

(b) The documentation required to support billing for BPHC services must meet the following standards:
(1) Reflect progress toward the goals reflected in the ~~recipient's~~ **member's** IICP.
(2) Be updated with every ~~recipient~~ **member** encounter when billing is submitted for reimbursement.
(3) Be written and signed by the agency staff rendering services.

(c) The documentation to support billing for BPHC services should:
(1) focus on recovery and habilitation or rehabilitation;
(2) support coordination or management of identified health needs and services; and
(3) emphasize ~~consumer~~ **member** strengths.

(d) Clinical documentation of services provided under this section must contain the following information:
(1) The type of service being provided.
(2) The names and qualifications of the staff providing the service.
(3) The location or setting where the service was provided.
(4) The focus of the session or service delivered to or on behalf of the ~~recipient.~~ **member.**
(5) The ~~recipient's~~ **member's** symptoms, needs, goals, or issues addressed during the session.
(6) The actual time spent rendering the service.
(7) The start and end time of the service.
(8) The ~~recipient's~~ **member's** IICP goal being addressed during the session.
(9) The progress made toward meeting goals noted on the IICP.
(10) The date of service rendered including month, day, and year.

(e) The content of the documentation must support the amount of time billed.

(f) For BPHC services provided on behalf of the ~~recipient~~ **member** without the ~~recipient~~ **member** present,

documentation must be provided for each encounter and must include the following information:

(1) The names of all persons attending the session and each person's relationship to the ~~recipient.~~ **member.**

(2) How the service:

(A) benefits the ~~recipient;~~ **member;** and

(B) assists the ~~recipient~~ **member** in reaching the IICP goals.

(g) A provider shall maintain documentation for services provided to a BPHC services ~~recipient~~ **member** in accordance with the requirements under 405 IAC 1-5-1.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-6; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 256. 405 IAC 5-21.8-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-7 BPHC services; general provisions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 7. (a) All BPHC services provided to a ~~recipient~~ **member** must meet the following requirements:

(1) Be supported by the ~~recipient's~~ **member's** level of need.

(2) Be documented in the ~~recipient's~~ **member's** IICP.

(b) Provider reimbursement for BPHC services is subject to, but not limited to, the following:

(1) The ~~recipient's~~ **member's** eligibility for services.

(2) The provider's qualifications and certification.

(3) The scope, limitations, and exclusions of the services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-7; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 257. 405 IAC 5-21.8-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-8 BPHC activities

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 8. (a) BPHC reimbursable activities consist of coordination of health care services to manage the health care needs of the ~~recipient.~~ **member.** The BPHC services include the following reimbursable activities:

(1) Logistical support.

(2) Advocacy and education to assist individuals in navigating the health care system.

(3) Activities that help ~~recipients:~~ **members:**

(A) gain access to needed health services; and

(B) manage their health conditions, including, but not limited to:

(i) adhering to health regimens;

(ii) scheduling and keeping medical appointments;

(iii) obtaining and maintaining a primary medical provider; and

(iv) facilitating communication across medical providers.

(4) Needs assessment.

(5) IICP development.

(6) Referral and linkage.

(7) Coordination of health services across systems.

(8) Monitoring and follow-up.

(9) Evaluation.

(b) This subsection defines the activities identified at subsection (a)(4) through (a)(9) as follows:

(1) Needs assessment consists of identifying the ~~recipient's~~ **member's** needs for coordination of health services. Specific assessment activities necessary to form a complete needs assessment of the ~~recipient~~

member may include the following:

(A) Taking the ~~recipient's~~ **member's** history.

(B) Identifying the ~~recipient's~~ **member's** needs.

(C) Completing related documentation.

(D) Gathering information from other sources, such as:

(i) family members; or

(ii) medical providers.

(2) IICP development activities include the development of a written IICP based upon the information collected during the needs assessment phase. An IICP shall include ~~recipient~~ **member**-driven goals for health care or lifestyle changes and identify the health activities and assistance needed to accomplish the ~~recipient's~~ **member's** objectives. An IICP may include activities and goals such as:

(A) referrals to medical services;

(B) education on health conditions;

(C) activities to ensure compliance with health regimens and health care provider recommendations; or

(D) activities or contacts necessary to ensure that the IICP is effectively implemented and adequately address the health needs of the individual.

(3) Referral and linkage include activities that help link the ~~recipient~~ **member** with medical providers and other programs and services that are capable of providing needed health services.

(4) Coordination of health services includes, but is not limited to, the following:

(A) Physician consults, defined as facilitating linkage and communication between medical providers.

(B) The BPHC provider serving as a communication conduit between the ~~consumer~~ **member** and specialty medical and behavioral health providers.

(C) Notification, with the ~~consumer's~~ **member's** consent, of changes in medication regimens and health status.

(D) Coaching ~~consumers~~ **members** to help them interact more effectively with providers.

(5) Monitoring and follow-up include the following:

(A) Face-to-face contact with the ~~recipient~~ **member** at least every ninety (90) days.

(B) Contacts and activities necessary to ensure that the IICP is effectively implemented and adequately addresses the needs of the ~~recipient.~~ **member.**

(C) Contacts and activities with the following individuals:

(i) The ~~recipient.~~ **member.**

(ii) Family members or others who have a significant relationship with the ~~recipient.~~ **member.**

(iii) Nonprofessional caregivers.

(iv) Providers.

(v) Other entities.

(6) Evaluation includes periodic reevaluation of the ~~recipient's~~ **member's** progress in order to:

(A) ensure the IICP is effectively implemented and adequately addresses the ~~recipient's~~ **member's** needs;

(B) determine whether the services are consistent with the IICP and any changes to the IICP;

(C) make changes or adjustments to the IICP in order to meet the ~~recipient's~~ **member's** ongoing needs; and

(D) evaluate the ~~recipient's~~ **member's** progress toward achieving the IICP's objectives.

(c) The time devoted to formal supervision between the BPHC provider and the licensed supervisor to review the ~~recipient's~~ **member's** care and treatment shall be:

(1) an included BPHC activity;

(2) documented in the ~~recipient's~~ **member's** clinical record; and

(3) billed under only one (1) provider staff member.

(d) The BPHC activities under subsection (b)(1) through (b)(3) and b(4)(A) must be delivered by provider staff who are one (1) of the following:

(1) A licensed professional.

(2) A QBHP.

(3) An OBHP.

(e) With the exception of those activities described in subsection (d), provider staff delivering services under this section must be one (1) of the following:

(1) A licensed professional.

(2) A QBHP.

(3) An OBHP.

(4) ~~A DMHA~~ **An office** CRS.

(5) ~~A DMHA~~ An **office**-certified community health worker.

(f) The following are not reimbursable under this section:
(1) Activities billed under behavioral health level of need redetermination.
(2) Activities billed under Medicaid rehabilitation option case management.
(3) Activities billed under adult mental health habilitation care coordination.
(4) Direct provision of medical services or treatment, including, but not limited to, the following:
(A) Medical screening such as blood pressure screenings or weight checks.
(B) Medication training and support.
(C) Individual, group, or family therapy services.
(D) Crisis intervention services.
(5) Services provided to the ~~recipient~~ **member** at the same time as another service that is the same in nature and scope, regardless of funding source.
(6) Services provided while the ~~recipient~~ **member** is in an institutional or noncommunity-based setting.
(7) Services provided in a manner that is not within the scope or limitations of a BPHC service.
(8) Services not documented as covered or approved on the ~~recipient's~~ **member's** ~~DMHA~~ **office**-approved IICP.
(9) Services not supported by documentation in the ~~recipient's~~ **member's** clinical record.
(10) Services provided that exceed the defined limits of the service, including service quantity, limits, duration, or frequency.
(11) Activities excluded from the service scope or definition.

(g) BPHC services are limited to a maximum of twelve (12) hours, or forty-eight (48) units, per six (6) months.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-8; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 258. 405 IAC 5-21.8-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-9 BPHC provider agency requirements

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 9. (a) In order to deliver the BPHC program under this rule, a provider must be a state-certified community mental health center approved by the ~~DMHA~~ **office** as a BPHC provider agency.

(b) Any provider wishing to apply to become a BPHC provider agency must:
(1) submit a completed BPHC provider agency application to the ~~DMHA~~ **office** for review and consideration; and
(2) be enrolled as a ~~Medicaid~~ provider.

(c) Provider agencies under this rule must attest that the staff members delivering BPHC allowable activities under this service meet the provider requirements and qualifications as defined in section 8(d) and 8(e) of this rule.

(d) Provider agencies approved to provide BPHC services under this rule are subject to the enforcement provisions in 405 IAC 1-1-6.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-9; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 259. 405 IAC 5-21.8-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-10 Fair hearings and appeals

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 10. (a) The following individuals may appeal an adverse agency action:
(1) An applicant.
(2) A ~~recipient of~~ **member who receives** services under this rule.
(3) A duly authorized representative of:
(A) an applicant; or
(B) a recipient.

(b) Administrative hearings and appeals by an applicant or recipient are governed by the procedures set forth in 405 IAC 1.1.

(c) The ~~DMHA~~ state evaluation team shall notify the following individuals of any such adverse agency action:
(1) The applicant or recipient.
(2) The duly authorized representative of the applicant or the recipient, if applicable.
(3) The BPHC provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-10; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 260. 405 IAC 5-21.8-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.8-11 Complaints and grievances

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 11. (a) The following individuals may file a written complaint or a written grievance with the state ~~the DMHA,~~ or the office:
(1) An applicant.
(2) A ~~recipient.~~ **member.**
(3) A duly authorized representative of:
(A) an applicant; or
(B) a ~~recipient.~~ **member.**

(b) Upon receipt of a complaint or grievance, the ~~DMHA~~ **office** shall:
(1) log the complaint or grievance; and
(2) initiate an investigation.

(c) The ~~DMHA's~~ **office's** decision with regard to a complaint or grievance is not appealable.

(d) The filing of a complaint or grievance is not a prerequisite to filing an appeal under section 10 of this rule.

(e) If the ~~DMHA~~ **office** issues findings regarding a complaint or a grievance of an applicant or a ~~recipient,~~ **member,** the ~~DMHA~~ **office** may require the provider agency to correct an identified deficiency within a timeline established by the ~~DMHA.~~ **office.** A provider agency's failure to correct the deficiency within the established timeline may result in sanctions up to and including decertification of the provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-11; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

SECTION 261. 405 IAC 5-22-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-1 Definitions

Authority: 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. 1. The following definitions apply throughout this rule:
(1) "Acute medical condition" means a condition with an onset within the preceding fourteen (14) days, and

sequelae of a temporary nature, including, but not limited to, sprains, spasms, infection, or joint inflammation.
(2) "Acute rehabilitation condition" means medical injury or insult, onset occurring within one (1) year, which results in impaired functioning. These conditions may include, but are not limited to, head injury, cerebrovascular accident (CVA), or fracture.
(3) "Applied behavioral analysis therapy services" or "ABA therapy services" means the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.
(4) "Chronic medical condition or rehabilitation condition" means any injury or insult with onset and sequelae extending past one (1) year.
(5) "Educational in nature" means instruction or training that develops the general abilities of the mind and results in learning new material, as opposed to restoring or establishing a normal condition.
(6) "Habilitative therapy" means therapy addressing chronic medical conditions where further progress can no longer be expected to lessen the deterioration of function over time. Habilitative therapy includes physical therapy, occupational therapy, respiratory therapy, speech-language pathology services, and audiology services provided to ~~recipients~~ **members** for the purpose of maintaining a level of functionality, but not the improvement of functionality. Although the development of a habilitation plan is considered part of rehabilitation services, the services furnished under a habilitation plan are not skilled therapy.
(7) "Licensed or board certified behavior analyst" means a behavior analyst with credentialing as a:
(A) board certified behavior analyst - doctoral (BCBA-D);
(B) board certified behavior analyst (BCBA); or
(C) board certified assistant behavior analyst (BCaBA).
(8) "Medically necessary therapy" means therapy for the restoration of an impaired level of function caused by an acute change in medical condition.
(9) "Outpatient therapy services" means services provided to a ~~recipient~~ **member** outside the ~~recipient's~~ **member's** primary place of residence.
(10) "Rehabilitative services" refers to the federal definition of rehabilitative services in 42 CFR 440.130(d) and includes physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services provided to ~~recipients.~~ **members.**
(11) "Respiratory therapy" or "RT" means the adjunctive treatment, management, and preventive care of patients with acute and chronic cardiac pulmonary problems.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 262. 405 IAC 5-22-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-2 Nursing services; prior authorization requirements

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 2. (a) Medicaid reimbursement is available for services rendered by registered nurses, licensed practical nurses, and home health agencies who are ~~Medicaid~~ providers, subject to the following:
(1) Prior authorization is required for all nursing services, except services ordered in writing by a physician prior to the recipient's discharge from an inpatient hospital, which may continue for a period not to exceed one hundred twenty (120) units within thirty (30) days of discharge without prior authorization and except as noted in subsection (c). Prior authorization requests may be submitted by an authorized representative of the home health agency. The prior authorization form must contain the information specified in 405 IAC 5-3-5. In addition, the following information must be submitted with the prior authorization request form:
(A) A copy of the written plan of treatment, signed by the attending physician.
(B) An estimate of the costs for the requested services as ordered by the physician and as set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.
(2) Prior authorization shall include consideration of the following:
(A) Written order of a physician.
(B) Services must be provided according to a plan of treatment developed in coordination with the attending physician.
(C) The attending physician must review the plan of treatment every sixty (60) days and reorder the service

if medically ~~reasonable and~~ necessary.
(D) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. A current plan of treatment and progress notes, as to the necessity and effectiveness of nursing services, must be attached to the prior authorization request and available for postpayment audit purposes.
(E) Additional hours of nursing service may be authorized for ventilator dependent patients who have a developed plan of home health care providing it is cost effective and prevents repeated or prolonged stays in an acute care facility.

(b) Reimbursement is not available for care provided by family members or other individuals residing with the recipient.

(c) Medicaid reimbursement is available for IEP nursing services when the services are medically necessary, consistent with the definition set forth in 405 IAC 5-2-13.2, and provided pursuant to a Medicaid enrolled student's IEP. The following apply to IEP nursing services:
(1) The IEP is the prior authorization for IEP nursing services, when provided by a Medicaid participating school corporation.
(2) The school corporation must bill for the appropriate start and stop time or times of IEP nursing services. Documentation of IEP nursing services must include:
(A) The start and stop time or times for each IEP nursing service provided per date of service.
(B) The place of service and a description of the beginning and ending date or dates and time or times if the IEP services provided off-site or during a school field trip.
(3) The Medicaid enrolled student's IEP must:
(A) specifically authorize the Medicaid covered IEP nursing service; and
(B) demonstrate there is a medical need for the IEP nursing service.
(4) The reimbursement rate will be set by the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; filed Sep 27, 1999, 8:55 a.m.: 23 IR 317; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 263. 405 IAC 5-22-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-6 Occupational, physical, and respiratory therapy and speech pathology; criteria for prior authorization

Authority: 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. 6. (a) Prior authorization is required for all therapy services with the following exceptions:
(1) Initial evaluations.
(2) Emergency respiratory therapy.
(3) Any combination of therapy ordered in writing prior to a ~~recipient's~~ **member's** discharge from an inpatient hospital that may continue for a period not to exceed thirty (30) units in thirty (30) calendar days.
(4) The deductible and copay for services covered by Medicare, Part B.
(5) Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators.
(6) Therapy services provided by a nursing facility or large private or small intermediate care facility for ~~the mentally retarded (ICF/MR),~~ **individuals with intellectual disabilities (ICF/IID),** which are included in the facility's per diem rate.
(7) Respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in section 10 of this rule.

(b) Unless specifically indicated otherwise, the following criteria for prior authorization of therapy services apply to occupational therapy, physical therapy, respiratory therapy, and speech pathology:
(1) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. Therapy must be ordered by a physician (doctor of medicine or doctor of osteopathy). A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must be attached to the prior authorization request and available for audit purposes.

(2) Therapy must be provided by a qualified therapist or qualified assistant under the direct supervision of the therapist as appropriate.
(3) Therapy must be of such a level of complexity and sophistication and the condition of the ~~recipient~~ **member** must be such that the judgment, knowledge, and skills of a qualified therapist are required.
(4) Medicaid reimbursement is available only for medically ~~reasonable and~~ necessary therapy.
(5) Therapy rendered for a diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities or for developmental activities that can be conducted by nonmedical personnel, is not covered by Medicaid.
(6) This subdivision applies to services for recipients twenty-one (21) years of age and older. Therapy for rehabilitative services will be covered for a ~~recipient~~ **member** twenty-one (21) years of age and older for no longer than two (2) years from the initiation of the therapy unless there is a significant change in the ~~recipient's~~ **member's** medical condition requiring longer therapy. Habilitative therapy is not a covered service for ~~recipients~~ **members** twenty-one (21) years of age and older. Respiratory therapy services are covered for ~~recipients~~ **members** twenty-one (21) years of age and older but for no longer than two (2) years from the date of initiation of the therapy. Respiratory therapy may be covered for a longer period of time on a case-by-case basis subject to prior authorization.
(7) This subdivision applies to services for ~~recipients~~ **members** under twenty-one (21) years of age. Therapy for rehabilitative services will be covered for a ~~recipient~~ **member** under twenty-one (21) years of age when determined to be medically necessary. Habilitative therapy services for ~~recipients~~ **members** under twenty-one (21) years of age will be covered on a case-by-case basis and are subject to prior authorization. Educational services, including, but not limited to, the remediation of learning disabilities, are not covered by Medicaid.
(8) When a ~~recipient~~ **member** is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. Ongoing evaluations are not separately reimbursed ~~under the~~ **by** Medicaid. ~~program.~~
(9) One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.
(10) Reimbursement for therapy services is limited to one (1) hour per day per type of therapy. Additional therapy services must be medically necessary and requires prior authorization.
(11) A request for therapy services, which would duplicate other services provided to a ~~recipient,~~ **member,** will not be prior authorized. Therapy services will not be authorized when such services duplicate nursing services required under 410 IAC 16.2-3.1-17.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; filed Sep 27, 1999, 8:55 a.m.: 23 IR 318; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 264. 405 IAC 5-22-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-7 Audiology services

Authority: 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. 7. (a) Audiology services are subject to the following restrictions:
(1) The physician must certify in writing the need for audiological assessment or evaluation.
(2) The audiology service must be rendered by a licensed audiologist or a person registered for his **or her** clinical fellowship year who is supervised by a licensed audiologist. A registered audiology aide can provide services under the direct on-site supervision of a licensed audiologist under 880 IAC 1-1.
(3) When a ~~recipient~~ **member** is to be fitted with a hearing amplification device, by either the audiologist or a registered hearing aid specialist, a medical clearance and audiometric test form must be completed in accordance with instructions given below and submitted with the request for prior authorization. This form must be complete and must include the proper signatures, where indicated, before the prior authorization request will be reviewed by the department.
(4) Initial audiological assessments are limited to one (1) assessment every three (3) years per ~~recipient.~~ **member.** If more frequent audiological assessments are necessary, prior authorization is required.

(b) Provision of audiology services are subject to the following criteria:
(1) All requests for prior authorization will be reviewed on a case-by-case basis by the contractor.
(2) ~~Recipient~~ **Member** history must be completed by any involved professional.

(3) The referring physician must complete Part 2 of the Medical Clearance and Audiometric Test Form no earlier than six (6) months prior to the provision of the hearing aid. Children fourteen (14) years of age and under must be examined by an otolaryngologist; older ~~recipients~~ **members** may be examined by a licensed physician if an otolaryngologist is not available.
(4) All testing must be conducted in a sound-free enclosure. If a ~~recipient~~ **member** is institutionalized and his or her physical or medical condition precludes testing in a sound-free enclosure, the ordering physician must verify medical confinement in the initial order for audiological testing. The audiological assessment must be conducted by a licensed audiologist, clinical fellowship year audiologist, or otolaryngologist. Testing conducted by other professionals and cosigned by an audiologist or otolaryngologist will not be reimbursed by Medicaid. If the audiological evaluation reveals one (1) or more of the following conditions, the ~~recipient~~ **member** must be referred to an otolaryngologist for further evaluation:
(A) Speech discrimination testing indicates a score of less than sixty percent (60%) in either ear.
(B) Pure tone testing indicates an air bone gap of fifteen (15) decibels or more for two (2) adjacent frequencies in the same ear.
(5) The hearing aid evaluation may be completed by the audiologist or registered hearing aid specialist. The results must be documented on the prior authorization request and indicate that significant benefit can be derived from amplification before prior authorization may be granted.
(6) The hearing aid contract portion of the audiometric test form must be signed by a registered hearing aid specialist.
(7) Audiological assessments rendered more frequently than every three (3) years will be assessed on a case-by-case basis, based upon documented otological disease.

(c) Audiologic procedures cannot be fragmented and billed separately. Hearing tests, such as whispered voice and tuning fork, are considered part of the general otorhinolaryngologic services and cannot be reported separately **as follows:**
(1) Basic comprehensive audiometry include pure tone, air and bone threshold and discrimination. The above descriptions refer to testing of both ears.
(2) All other audiometric testing procedures will be reimbursed on an individual basis, based on only the medical necessity of such test procedures.

(d) The following audiological services do not require prior authorization:
(1) A screening test indicating the need for additional medical examination. Screenings are not reimbursed separately ~~under the~~ **by** Medicaid. ~~program.~~
(2) The initial assessment of hearing.
(3) Determination of suitability of amplification and the recommendation regarding a hearing aid.
(4) The determination of functional benefit to be gained by the use of a hearing aid.
(5) Audiology services provided by a nursing facility or large private or small ~~ICF/MR,~~ **ICF/IID,** which are included in the facility's established per diem rate.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3340; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 265. 405 IAC 5-22-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-8 Physical therapy services

Authority: 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 physical therapist's assistant under the direct supervision of a licensed physical therapist or physician as defined in 844 IAC 6-1-2(g) for reimbursement. Only the activities in this subdivision related to the therapy can be performed by someone other than a licensed therapist or certified physical therapist's assistant who must be under the direct 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(g).

(3) Evaluations and reevaluations are limited to three (3) hours of service per ~~recipient~~ **member** 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.

(4) Physical therapy services provided by a nursing facility or large private or small ~~ICF/MR,~~ **ICF/IID,** 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; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1902; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 266. 405 IAC 5-22-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-9 Speech pathology services

Authority: 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. 9. Speech pathology services are subject to the following restrictions:

(1) The speech pathology service must be rendered by a licensed speech-language pathologist or a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist. A registered speech-language pathology aide may provide services subject to ~~880 IAC 1-2~~. **880 IAC 1-2.1.**

(2) Evaluations and reevaluations are limited to three (3) hours of service per 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 speech pathology 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) Group therapy is covered in conjunction with, not in addition to, regular individual treatment. Medicaid will not pay for group therapy as the only or primary means of treatment.

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

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 267. 405 IAC 5-22-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-10 Respiratory therapy services

Authority: 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. 10. Respiratory therapy services are subject to the following restrictions:

(1) Respiratory therapy services will be reimbursed only when performed by a licensed respiratory therapist or a certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic.
(2) The equipment necessary for rendering respiratory therapy will be considered part of the provider's capital equipment.
(3) Oxygen provided in a nursing facility does not require prior authorization if oxygen is ordered in writing by a physician.
(4) Respiratory therapy given on an emergency basis does not require prior authorization.
(5) Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, and upper respiratory infection may be provided without prior authorization for a period not to exceed fourteen (14) hours on fourteen (14) calendar days. If additional services are required after that date, prior authorization must be obtained.
(6) Respiratory therapy services provided by a nursing facility or large private or small ~~ICF/MR,~~ **ICF/IID,** which are included in the facility's established per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 268. 405 IAC 5-22-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-11 Occupational therapy services

Authority: 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. 11. Occupational therapy services are subject to the following restrictions:
(1) Occupational therapy services must be performed by a licensed occupational therapist or by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist. An evaluation must be performed by a licensed occupational therapist in order for reimbursement to be made.
(2) Evaluations and reevaluations are limited to three (3) hours of service per 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 occupational therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the ~~recipient's~~ **member's** condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.
(3) General strengthening exercise programs for recuperative purposes are not covered by Medicaid.
(4) Passive range of motion services are not covered by Medicaid as the only or primary modality of therapy.
(5) Medicaid reimbursement is not available for occupational therapy psychiatric services.
(6) Occupational therapy services provided by a nursing facility or large private or small ~~ICF/MR,~~ **ICF/IID,** which are included in the facility's established per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 269. 405 IAC 5-23-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-23-2 Initial examinations

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 25-24-1-4

Sec. 2. (a) Reimbursement for the initial vision care examination will be limited to:
(1) one (1) examination per year for a ~~recipient~~ **member** under twenty-one (21) years of age; and
(2) one (1) examination every two (2) years for a ~~recipient~~ **member** twenty-one (21) years of age or older.
If medical necessity dictates more frequent examination or care, documentation of such medical necessity must be maintained in the provider's office. The documentation shall be subject to postpayment review and audit.

(b) An initial examination is the initial vision care service performed for the determination of the need for additional vision care services. Medical necessity will determine which type of initial exam will be given. The frequency of vision care services is subject to the limitations listed in subsection (a). The initial examination may include the following:

(1) An eye examination, including history.
(2) Visual acuity determination.
(3) External eye examination.
(4) Biocular measure.
(5) Routine ophthalmoscopy.
(6) Tonometry and gross visual field testing, including:
  (A) color vision;
  (B) depth perception; or
  (C) stereopsis.

(Office of the Secretary of Family and Social Services; 405 IAC 5-23-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3343; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 4:00 p.m.: 20110608-IR-405100794FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 270. 405 IAC 5-23-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-23-3 Covered vision care services

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 25-24-1-4

Sec. 3. The following services, if medically necessary, may be provided in addition to the initial examination:

(1) Supplemental evaluation.
(2) Multiple pattern fields, including Roberts, Harrington, or Flods.
(3) Central field study.
(4) Peripheral field study.
(5) Tangent screen study.
(6) Color field study.
(7) Binocular ophthalmoscope.
(8) Other supplemental testing.
(9) Visual skills study.
(10) Clinical photography.
(11) Bifocal determination.
(12) Trifocal determination.
(13) Definitive fundus evaluation.
(14) Electrophysiology.
(15) Gonioscopy.
(16) Out-of-office visits.
(17) Neutralization of lens or lenses.
(18) Neutralization of contact lenses.
(19) Extended ophthalmoscopy.
(20) Serial tonometry.
(21) Refractions.
(22) Office visit.
(23) Consultation.
(24) Visual skills testing.

Screening services (excluding EPSDT) for ~~recipients~~ **members** are not covered by Medicaid, and payment will not be made for such care. All services provided to recipients in long term care facilities must be documented in the recipient medical record that is maintained by the facility.

(Office of the Secretary of Family and Social Services; 405 IAC 5-23-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3343; filed Sep 27, 1999, 8:55 a.m.: 23 IR 318; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 271. 405 IAC 5-23-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-23-4 Frames and lenses; limitations

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 25-24-1-4

Sec. 4. The provision of frames and lenses are subject to the following limitations:
(1) Reimbursement will be made for frames, including, but not limited to, plastic or metal. The maximum amount reimbursed for frames is twenty dollars ($20) per pair except when medical necessity requires a more expensive frame. Situations where medical necessity for a more expensive frame may be indicated include, but are not limited to, the following:
(A) Frames to accommodate facial asymmetry or other anomalies of the:
(i) head;
(ii) neck;
(iii) face; or
(iv) nose.
(B) Allergy to standard frame materials.
(C) Specific lens prescription requirements.
(D) Frames with special modifications such as a ptosis crutch.
(E) Provision of frames to an infant where special size frames must be prescribed that are unavailable for twenty dollars ($20) or less.
All Medicaid claim forms submitted for a more expensive frame must be accompanied by medical necessity documentation.
(2) Fashion tints, gradient tints, sunglasses, or photochromatic lenses are not covered. Tint numbers 1 and 2 are covered, for example, the following:
(A) Rose A.
(B) Pink 1.
(C) Soft lite.
(D) Cruxite.
(E) Velvet lite.
(3) Except when medical necessity is documented, lenses larger than size 61 millimeters are not covered.
(4) All Medicaid claim forms submitted for vision materials must be accompanied by a valid copy of the laboratory invoices.
(5) Reimbursement for eyeglasses provided to a ~~recipient~~ **member** under twenty-one (21) years of age will be limited to a maximum of one (1) pair per year only if the criteria set out in subdivision (7) have been met. The office will provide reimbursement for repairs or replacements of eyeglasses only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the ~~recipient's~~ **member's** control, for example, fire, theft, or automobile accident. The documentation of the extenuating circumstances:
(A) must be maintained in the provider's office; and
(B) shall be subject to postpayment review and audit.
(6) Reimbursement for eyeglasses provided to a ~~recipient~~ **member** twenty-one (21) years of age or over is limited to a maximum of one (1) pair every five (5) years if the criteria set out in subdivision (7) have been met. Replacements will only be covered under subdivision (5).
(7) The office shall not provide reimbursement for an initial or subsequent pair of glasses unless the minimum prescription or change meets the following criteria:
(A) For one (1) eye, a minimum initial prescription or, for a subsequent pair of glasses, a change of seventy-five hundredths (.75) diopters for a patient six (6) to forty-two (42) years of age and fifty-hundredths (.50) diopters prescription or change for a patient over forty-two (42) years of age.
(B) An axis change of at least fifteen (15) degrees.
When provided in accordance with subdivisions (5) and (6), glasses that meet the criteria of this subdivision may be provided without prior authorization.
(8) Safety lenses are covered only for corneal lacerations or other severe intractable ocular or ocular adnexal disease.

(Office of the Secretary of Family and Social Services; 405 IAC 5-23-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3343; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 4:00 p.m.: 20110608-IR-405100794FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 272. 405 IAC 5-24-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-1 Reimbursement policy

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

Sec. 1. (a) This section represents the Medicaid medical policy and covered service limitations with respect to pharmacy services provided by a ~~Medicaid enrolled~~ pharmacy provider. Medicaid reimbursement is available for pharmacy services rendered by ~~enrolled~~ pharmacy providers, when such services are:

(1) provided in accordance with all applicable laws, rules of the office, and Medicaid provider manual; and

(2) not specifically excluded from coverage by rules of the office.

(b) Reimbursement is not available for any costs associated with unit of use packaging or unit dose packaging when the pharmacy provider repackages medications or any drug.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3344; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 273. 405 IAC 5-24-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-3 Coverage of legend drugs

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

Sec. 3. (a) A legend drug is covered by ~~Indiana~~ Medicaid if the drug is:

(1) approved by the United States Food and Drug Administration;

(2) not designated by the Health Care Financing Administration as less than effective, or identical, related, or similar to a less than effective drug;

(3) subject to the terms of a rebate agreement between the drug's manufacturer and the HCFA; and

(4) not specifically excluded from coverage by ~~Indiana~~ Medicaid.

(b) The following are not covered by ~~Indiana~~ Medicaid:

(1) Anorectics or any agent used to promote weight loss.

(2) Topical minoxidil preparations.

(3) Fertility enhancement drugs.

(4) Drugs when prescribed solely or primarily for cosmetic purposes.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; filed Sep 27, 1999, 8:55 a.m.: 23 IR 319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 274. 405 IAC 5-24-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-4 Reimbursement for legend drugs

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

Sec. 4. (a) The office shall reimburse pharmacy providers for covered legend drugs at the lowest of the following:

(1) The estimated acquisition cost (EAC) of the drug as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(2) The state maximum allowable cost (MAC) of the drug as determined by the office as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(3) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

(b) For purposes of this section and section 5(c) of this rule, the ~~Indiana~~ Medicaid EAC is:
(1) for brand name drugs, eighty-four percent (84%); or
(2) for generic drugs, eighty percent (80%);
of the average wholesale price for each National Drug Code according to the ~~Medicaid contractor's~~ **office's** drug database file.

(c) The state MAC is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual acquisition cost will be determined using pharmacy invoices and other information that the office determines is necessary. The purpose of the multiplier is to ensure that the applicable state MAC rate is sufficient to allow reasonable access by providers to the drug at or below the established state MAC rate.

(d) ~~OMPP~~ **The office** will review state MAC rates on an ongoing basis and adjust the rates as necessary to:
(1) reflect prevailing market conditions; and
(2) ensure reasonable access by providers to drugs at or below the applicable state MAC rate.

(e) Pharmacies and providers that are enrolled in Medicaid are required, as a condition of participation, to make available and submit to the office ~~or its designee~~ acquisition cost information, product availability information, or other information deemed necessary by the office for the efficient operation of the pharmacy benefit in the format requested by the office. ~~or its designee.~~ Providers will:
(1) not be reimbursed for this information; and
(2) submit information to the office ~~or its designee~~ within thirty (30) days following a request for such information unless the office ~~or its designee~~ grants an extension upon written request of the pharmacy or provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2001, 9:50 a.m.: 25 IR 60 [NOTE: On October 9, 2001, the Marion Superior Court issued an Order in Cause No. 49D05-0109-CP-1480, enjoining the Family and Social Services Administration from implementing LSA Document #01-22(F), published at 25 IR 60.]; filed Apr 30, 2002, 10:59 a.m.: 25 IR 2727; errata filed Aug 22, 2002, 3:11 p.m.: 26 IR 35; filed Nov 23, 2005, 11:30 a.m.: 29 IR 1212; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jan 23, 2008, 1:42 p.m.: 20080220-IR-405070547FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 275. 405 IAC 5-24-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-6 Dispensing fee

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 6. (a) For purposes of this rule, through June 30, 2017, the ~~Indiana~~ Medicaid dispensing fee maximum is three dollars and ninety cents ($3.90) per legend drug.

(b) A maximum of one (1) dispensing fee per month is allowable per ~~recipient~~ **member** per drug order for legend drugs provided to ~~Medicaid recipients~~ **members** residing in Medicaid certified long-term care facilities.

(c) The practice of split billing of legend drugs, defined as the dispensing of less than the prescribed amount of drug solely for the purpose of collecting more dispensing fees than would otherwise be allowed, is prohibited. In cases in which the pharmacist's professional judgment dictates that a quantity less than the amount prescribed be dispensed, the pharmacist should contact the prescribing practitioner for authorization to dispense a lesser quantity. The pharmacist must document the result of the contact and the pharmacist's rationale for dispensing less than the amount prescribed on the prescription or in the pharmacist's records.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2001, 9:50 a.m.: 25 IR 60 [NOTE: On October 9, 2001, the Marion Superior Court issued an Order in Cause No. 49D05-0109-CP-1480, enjoining the Family and Social Services Administration from implementing LSA Document #01-22(F), published at 25 IR 60.]; filed Apr 30, 2002, 10:59 a.m.: 25 IR 2727; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.:

20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 276. 405 IAC 5-24-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-7 Copayment for legend and nonlegend drugs

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

Sec. 7. (a) Under IC 12-15-6, a copayment is required for legend and nonlegend drugs and insulin in accordance with the following:

(1) The copayment shall be paid by the ~~recipient~~ **member** and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the ~~recipient~~ **member** is liable.

(2) In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under 42 CFR 447.15, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

(3) The amount of the copayment will be three dollars ($3) for each covered drug dispensed.

The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid.

(b) The following pharmacy services are exempt from the copayment requirement:

(1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.

(2) Services furnished to individuals less than eighteen (18) years of age.

(3) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy.

(4) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for ~~the mentally retarded,~~ **individuals with intellectual disabilities,** or other medical institutions.

(5) Family planning services and supplies furnished to individuals of child bearing age.

(6) Health maintenance organization (HMO) pharmacy services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Nov 4, 2002, 12:16 p.m.: 26 IR 732; filed Feb 24, 2004, 10:45 a.m.: 27 IR 2252; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 277. 405 IAC 5-24-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-9 Food supplements, nutritional supplements, and infant formulas

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

Sec. 9. (a) Food supplements, nutritional supplements, and infant formulas are covered only when no other means of nutrition is feasible or reasonable. Prior authorization for these items is required. Approval is subject to the following criteria:

(1) The feasibility or reasonableness of other means of nutrition, as documented by the requesting practitioner, and as determined by the office's contractor on a case-by-case basis.

(2) Authorization will not be granted when convenience of the ~~recipient~~ **member** or the ~~recipient's~~ **member's** caretaker is the primary reason for the request for the service.

(3) Coverage is not available in cases of routine or ordinary nutritional needs.

(4) Coverage is not available in cases in which the item is to be used for other than nutritional purposes.

(5) In a long term care facility setting, costs for these products, when utilized either for nutritional supplementation or as the sole source of nutrition for the resident, are included in the facility's established per diem rate. When these products are furnished to a long term care facility resident, they are not separately reimbursable by Medicaid and are not to be billed separately to Medicaid by either the long term care facility or another ~~Medicaid~~ provider furnishing the products.

(b) Hyperalimentation and total parenteral nutritional products do not require prior authorization. These products may be separately billed to Medicaid for residents of long term care facilities.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 278. 405 IAC 5-24-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-13 Legend and nonlegend solutions for nursing facility residents

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

Sec. 13. The cost of legend and nonlegend water products used for irrigation or humidification are included in the per diem rate for nursing facilities. When water products used for irrigation or humidification are furnished to a nursing facility resident, they are not separately reimbursable by Medicaid and are not to be billed separately to Medicaid by either the nursing facility or another ~~Medicaid~~ provider furnishing the products, as set forth in 405 IAC 5-31-4(7). Water agents used (or to be used) as a vehicle to deliver a drug therapy into the body must be reimbursed through the pharmacy benefit and not included in the nursing facility per diem reimbursement.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-13; filed Jun 5, 2003, 8:35 a.m.: 26 IR 3633, eff on the first day of the calendar quarter following the thirtieth day after filing with the secretary of state; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 279. 405 IAC 5-25-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-25-1 Applicability

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

Sec. 1. Medicaid reimbursement is available for medically necessary ~~and reasonable~~ services provided by a doctor of medicine or doctor of osteopathy for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within the scope of the practice of medicine, as defined by Indiana law, when provided to ~~recipients,~~ **members,** except as provided in this rule. Medical services provided directly to a ~~recipient~~ **member** by a doctor of medicine or doctor of osteopathy do not require prior authorization, except as specified in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-25-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3347; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 280. 405 IAC 5-25-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-25-2 Reimbursement exclusions and limitations

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 2. (a) Medicaid will not reimburse a physician for the following:
(1) Preparation of reports.
(2) Missed appointments.
(3) Writing or telephoning prescriptions to pharmacies.
(4) Telephone calls to laboratories.
(5) Any extra charge for after-hours services.
(6) Mileage.

(b) Medicaid reimbursement is available for a physician as an assistant surgeon with the following restrictions:
(1) If extenuating circumstances require an assistant surgeon when customarily one is not required:

(A) these circumstances must be well documented in the hospital record; and
(B) documentation must be attached to the claim form.
(2) Reimbursement is not available for a surgical assistant who assists in diagnostic surgical procedures or for minor surgical procedures.
(3) Reimbursement is limited to the procedures that generally require the skills and services of an assistant surgeon as set out in HCPCS.

(c) A physician visiting more than one (1) ~~Medicaid recipient~~ **member** in the same long-term care facility on the same day will be reimbursed for each patient seen in an amount equal to the physician's routine office service allowance.

(d) Office visits will be reimbursed up to thirty (30) per calendar year, per ~~recipient,~~ **member,** per provider. Prior authorization will be given for more frequent visits if medically necessary.

(e) Any physician services subject to prior authorization rendered during an office visit that were not prior authorized will not be reimbursed.

(f) Reimbursement for any physician service rendered during an office visit that is subsequently found not be medically necessary is subject to recoupment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-25-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3347; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 5, 2010, 2:10 p.m.: 20101201-IR-405090928FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 281. 405 IAC 5-25-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-25-4 Injections administered by physicians

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

Sec. 4. Medicaid reimbursement is not available to a physician for injecting medications that can be self-administered unless justified by the patient's condition. Possible noncompliance by a ~~recipient~~ **member** to oral medication is insufficient justification to administer injections.

(Office of the Secretary of Family and Social Services; 405 IAC 5-25-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3348; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 282. 405 IAC 5-26-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-26-5 Prior authorization

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

Sec. 5. (a) Prior authorization by the office is required for the following:
(1) Hospital stays as outlined in 405 IAC 5-17.
(2) When a podiatrist prescribes or supplies corrective features built into shoes, such as heels, lifts, and wedges, for a ~~recipient~~ **member** under twenty-one (21) years of age.
(3) When a podiatrist fits or supplies orthopedic shoes for a ~~recipient~~ **member** with severe diabetic foot disease subject to the restrictions and limitations outlined 405 IAC 5-19.

(b) Medicaid reimbursement is available for the following surgical procedures without prior authorization:
(1) Surgical cleansing of the skin.
(2) Drainage of skin abscesses.
(3) Drainage or injections of a joint or bursa.

(4) Trimming of skin lesions.

Reimbursement for other surgical procedures performed within the scope of the podiatrist's license is available subject to the prior authorization requirements of 405 IAC 5-3.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3349; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2134; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 283. 405 IAC 5-26-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-26-6 Orthotic services

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

Sec. 6. Medicaid reimbursement is available when a podiatrist renders orthotic services as covered by Medicare for all eligible ~~recipients~~ **members** receiving both Medicare and Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3349; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 284. 405 IAC 5-26-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-26-7 Podiatric office visits

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

Sec. 7. (a) Medicaid reimbursement is available for podiatric office visits, subject to the following restrictions:
(1) Reimbursement is limited to one (1) office visit per twelve (12) months, per ~~recipient.~~ **member.**
(2) New patient office visits are limited to one (1) per ~~recipient,~~ **member,** per provider, within the last three (3) years. As used in this subdivision, "new patient" is one who has not received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three (3) years.
(3) A visit may be billed separately only on the initial visit. For subsequent visits, a visit may be billed only if a significant additional problem is addressed.

(b) Reimbursement is not available for the following types of extended or comprehensive office visits:
(1) New patient comprehensive.
(2) Established patient detailed.
(3) Established patient comprehensive.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3349; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 285. 405 IAC 5-26-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-26-10 Surgical procedures; confirmatory consultations

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

Sec. 10. (a) ~~Medicaid~~ Providers may be required, based upon the facts of the case, to obtain a confirmatory consultation in accordance with 405 IAC 5-8 substantiating the medical necessity or approach for the following surgical procedures:
(1) Bunionectomy procedures.
(2) All surgical procedures involving the foot.

(b) The confirmatory consultation is required regardless of the surgical setting in which the surgery is to be performed, including ambulatory surgical treatment center, hospital, clinic, or office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3350; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 286. 405 IAC 5-27-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-27-1 Reimbursement limitations

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

Sec. 1. (a) Medicaid reimbursement is available to radiology inpatient and outpatient facilities, freestanding clinics, and surgical centers for services provided to ~~recipients~~ **members** subject to the following limitations:

(1) Prior authorization is required for any radiological services that exceed the utilization parameters set out in this article.

(2) To be eligible for reimbursement, a radiological service must be ordered in writing by a physician or other practitioner authorized to do so under state law.

(3) Radiological service facilities must bill Medicaid directly for components provided by the facility. When two (2) practitioners separately provide a portion of the radiology service, each practitioner shall bill Medicaid directly for the component he or she provides. Medicaid will reimburse a physician or other practitioner for radiological services only when such services are performed under the physician's or practitioner's direct supervision.

(b) Radiology procedures cannot be fragmented and billed separately. Such procedures may include, but are not limited to, the following:

(1) CPT codes for supervision and interpretation procedures will not be reimbursed when the same provider bills for the complete procedure CPT code.

(2) If two (2) provider specialties are performing a radiology procedure, the radiologist shall bill for the supervision and interpretation procedure with the second physician billing the appropriate injection, aspiration, or biopsy procedure.

(3) Angiography procedures when performed as an integral component of a surgical procedure by the operating physician will not be reimbursed. Such procedures include, but are not limited to, the following:

(A) Angiography injection procedures during coronary artery bypass graft.

(B) Peripheral percutaneous transbiminal angeoplasty procedures.

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3350; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 287. 405 IAC 5-28-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-28-1 Reimbursement limitations

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

Sec. 1. (a) All levels of medical care, prior to surgical procedures, will be reimbursed on an individual basis based on documentation of the ~~patient's~~ **member's** medical condition. All levels of preoperative and postoperative care will be based on criteria set out in this rule.

(b) If the surgeon is doing the surgery only, and not the routine preoperative and postoperative care, this information must be indicated on the surgeon's claim form.

(c) If the primary care physician is rendering the preoperative or postoperative care only, this information must be indicated on the claim form and the name and address of the operating surgeon.

(d) If the ~~patient's~~ **member's** condition requires additional medical or surgical care outside the scope of the operating surgeon, then reimbursement for medical components will be considered on an individual basis.

(e) Medical visits made for surgical complications may be reimbursed only if medically indicated and no other physician has billed for the same or related diagnosis. The claim must indicate the specific complications. These medical visits are billed separately from the surgical fee.

(f) If visits are made for treatment of a condition other than the surgery related diagnosis and no other physician has billed for the same or related diagnosis, then these visits are billed separately from the surgical fee. Associated medical care for denied surgical procedures will also be denied.

(g) When two (2) or more covered surgical procedures are done during the same operative session, multiple surgery reductions shall apply to the procedures based on the following adjustments:
(1) One hundred percent (100%) of the global fee for the most expensive procedure.
(2) Fifty percent (50%) of the global fee for the second most expensive procedure.
(3) Twenty-five percent (25%) of the global fee for the remaining procedures.

(h) Surgical procedures, including diagnostic surgical procedures, may not be fragmented and billed separately. Such procedures are generally included in the major procedure. Such procedures may include, but are not limited to, the following:
(1) Exploratory laparotomy when done with an intra-abdominal procedure.
(2) Scope procedures used for the surgical procedure approach.
(3) Arthroscopy/arthrotomy procedures in the same area as a major joint procedure unless claim documents a second incision was made.
(4) Local anesthesia administered to perform the surgical/diagnostic procedure.
(5) Pelvic exam under anesthesia when performed during the same operative session as vaginal procedure, ~~dilatation~~ **dilation** and curettage (D&C), and laparoscopy procedures.

(i) A surgical procedure generally includes the preoperative visits performed on the same day or the day prior to the surgery for major surgical procedures, and the day of the surgical procedure for minor surgical procedures. Separate reimbursement is available for preoperative care when the ~~patient~~ **member** has never been seen by the provider performing the surgery, or the decision to perform surgery was made during the preoperative visit. The postoperative care days for a surgical procedure include ninety (90) days following a major surgical procedure and ten (10) days following a minor surgical procedure. Separate reimbursement is available for care provided during the global postoperative period that is unrelated to the surgical procedure, or for care rendered that is not considered routine postoperative care for the surgical condition, such as complications.

(j) Prior authorization is required for all procedures as listed in 405 IAC 5-17-2.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3352; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 288. 405 IAC 5-28-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-28-4 Single-chamber cardiac pacemaker implantation

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

Sec. 4. (a) Reimbursement for single-chamber pacemaker implantation, in the absence of special medical circumstances documented in the medical record that the procedure is medically beneficial, is not available for the following:
(1) Syncope of undetermined cause.
(2) Sinus bradycardia without significant symptoms.
(3) Sinoatrial block or sinus arrest without significant symptoms.
(4) Prolonged PR intervals (slow ventricular response) with atrial fibrillation without third degree atrial

ventricular (AV) block.
(5) Bradycardia during sleep.
(6) Right bundle branch block with left axis deviation and other forms of fascicular or bundle branch blocks without significant signs or symptoms.
(7) Asymptomatic second degree AV block of Mobitz Type I (Wenckebach).

(b) Reimbursement is available when the medical record documents that the ~~recipient~~ **member** has any of the following:
(1) Acquired complete (also referred to as third degree) AV heart block.
(2) Congenital complete heart block with severe bradycardia in relation to age or significant physiological deficits or significant symptoms due to the bradycardia.
(3) Second degree AV heart block of Type II.
(4) Second degree AV heart block of Type I.
(5) Sinus bradycardia associated with major symptoms or substantial sinus bradycardia with heart rate less than fifty (50) associated with dizziness or confusion. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
(6) Sinus bradycardia of lesser severity (heart rate fifty (50) to fifty-nine (59)) with dizziness or confusion. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
(7) Sinus bradycardia, which is the consequence of long term necessary drug treatment for which there is no acceptable alternative, when accompanied by significant symptoms. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
(8) Sinus node dysfunction, with or without tachyarrhythmias or AV conduction block, when accompanied by significant symptoms.
(9) Sinus node dysfunction, with or without symptoms, when there are potentially life-threatening ventricular arrhythmias or tachycardia secondary to the bradycardia.
(10) Bradycardia associated with supraventricular tachycardia with high degree AV block, which is unresponsive to appropriate pharmacological management and when the bradycardia is associated with significant symptoms.
(11) Hypersensitive carotid sinus syndrome with syncope due to bradycardia and unresponsive to prophylactic medical measures.
(12) Bifascicular or trifascicular block accompanied by syncope, which is attributed to transient complete heart block after other plausible causes of syncope have been reasonably excluded.
(13) Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third degree) or Mobitz Type II second degree AV block in association with bundle branch block.
(14) Recurrent and refractory ventricular tachycardia, overdrive pacing (pacing above the basal rate) to prevent ventricular tachycardia.
(15) Second degree AV heart block of Type I with the QRS complexes prolonged.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3353; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 289. 405 IAC 5-28-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-28-5 Dual-chamber cardiac pacemaker implantation

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

Sec. 5. (a) Medicaid reimbursement is available for dual-chamber cardiac pacemaker implantations. Medicaid reimbursement is subject to the restrictions set forth in this rule.

(b) Reimbursement is available for implantation of a dual-chamber cardiac pacemaker provided that the conditions are as follows:
(1) Chronic or recurrent.
(2) Not due to transient causes such as acute myocardial infarction, drug toxicity, or electrolyte imbalance.

(c) Reimbursement for a dual-chamber pacemaker implantation is not available when the ~~recipient~~ **member** has the following:
(1) Ineffective atrial contractions.
(2) Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of the tachycardia.
(3) A clinical condition in which pacing takes place only intermittently and briefly and is not associated with a reasonable likelihood that pacing needs will become prolonged.
(4) Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third degree) or Type II second degree AV block in association with bundle branch block.

(d) Reimbursement is available when the medical record documents that the ~~recipient~~ **member** has any of the following:
(1) A definite drop in blood pressure, retrograde conduction, or discomfort during insertion of a single-chamber (ventricular) pacemaker.
(2) Pacemaker syndrome (atrial ventricular asynchrony) with significant symptoms with a pacemaker that is being replaced.
(3) A condition in which even a relatively small increase in cardiac efficiency will importantly improve the quality of life.
(4) A condition in which the pacemaker syndrome can be anticipated.

(e) Dual-chamber pacemakers shall also be covered for the conditions, as listed in section 4 of this rule, for single-chamber cardiac pacemakers, if medically necessary. The physician's judgment that such a pacemaker is warranted in the ~~recipient,~~ **member,** meeting requirements of section 4 of this rule, must be based upon the individual needs and characteristics of that ~~recipient~~ **member** weighing the magnitude and likelihood of anticipated benefits against the magnitude and likelihood of disadvantages of the ~~recipient.~~ **member.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3354; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 290. 405 IAC 5-28-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-28-8 Sterilization

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

Sec. 8. Medicaid reimbursement is available for sterilization with the following restrictions:
(1) Sterilization procedures must comply with the mandates of federal rules.
(2) The ~~patient~~ **member** must be twenty-one (21) years of age or older at the time the informed consent form is signed.
(3) The ~~patient~~ **member** must be neither mentally incompetent nor institutionalized.
(4) The ~~patient~~ **member** must have voluntarily given informed consent on forms prescribed for such purposes by the federal Department of Health and Human Services.
(5) All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement shall be made.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3355; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 291. 405 IAC 5-28-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-28-9 Hysterectomy

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

Sec. 9. Medicaid reimbursement is available for the performance of hysterectomies with the following restrictions:

(1) Hysterectomy procedures must comply with federal regulations.

(2) A hysterectomy performed solely for the purpose of rendering a woman permanently incapable of reproducing, whether performed as a primary or secondary procedure, is not reimbursable by Medicaid.

(3) The acknowledgement of the hysterectomy information statement must be signed by the ~~recipient,~~ **member,** or ~~recipient's~~ **member's** representative, but is not required where the ~~recipient~~ **member** is already sterile or where a life-threatening emergency situation exists. Where the hysterectomy is performed on an already sterile ~~patient,~~ **member,** the physician who performs the hysterectomy must certify in writing that the ~~recipient~~ **member** was already sterile at the time the hysterectomy was performed and state the cause of the sterility.

(4) Where the hysterectomy is performed under a life-threatening emergency situation, the physician who performed the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation and that prior acknowledgement was not possible. The physician must include a description of the nature of the life-threatening emergency.

(5) The individual must be informed orally and in writing that this procedure will render her permanently incapable of reproducing, and she must sign a written acknowledgement of receipt of this information.

(6) Hysterectomy is subject to prior authorization. Where the hysterectomy is performed under a life-threatening emergency situation, the physician shall notify the ~~contractor~~ **office** within forty-eight (48) hours of the procedure, not including Saturday, Sunday, and legal holidays, to obtain prior authorization.

(7) All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement may be made.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3355; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 292. 405 IAC 5-29-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-29-1 Noncovered services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 1. The following services are not covered by Medicaid:

(1) Services that are not medically ~~reasonable or~~ necessary. ~~as defined in this article.~~

(2) Services provided outside the scope of a provider's license, registration, certification, or other authority to practice under state or federal law.

(3) Experimental drugs, treatments, or procedures, and all related services.

(4) Any new product, service, or technology not specifically covered in this article. The product, service, or technology will remain a noncovered product, service, or technology until such time as the office authorizes the coverage of the product, service, or technology. This subdivision does not apply to legend drugs.

(5) Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental.

(6) Services for the remediation of learning disabilities.

(7) Treatments or therapies of an educational nature.

(8) Experimental radiological or surgical or other modalities and procedures, including, but not limited to, the following:

(A) Acupuncture.

(B) Biofeedback therapy.

(C) Carbon dioxide five percent (5%) inhalator therapy for inner ear disease.

(D) Hyperthermia.

(E) Hypnotherapy.

(9) Hair transplants.

(10) Fallopian tuboplasty (reanastomosis of the fallopian tubes) for infertility or vasovasostomy (reanastomosis of the vas deferens. This procedure is covered only in conjunction with disease.

(11) Augmentation mammoplasties for cosmetic purposes.

(12) Dermabrasion surgery for acne pitting or marsupialization.

(13) Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem.

(14) Otoplasty for protruding ears unless one (1) of the following applies to the case:

(A) Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment, for example,

Pierre Robin syndrome.
(B) A ~~recipient~~ **member** has pending or actual employment where protruding ears would interfere with the wearing of required protective devices.
(15) Scar removals or tattoo removals by excision or abrasion.
(16) Ear lobe reconstruction.
(17) Removal of keloids caused from pierced ears unless one (1) of the following is present:
(A) Keloids are larger than three (3) centimeters.
(B) Obstruction of the ear canal is fifty percent (50%) or more.
(18) Rhytidectomy.
(19) Penile implants.
(20) Perineoplasty for sexual dysfunction.
(21) Reconstructive or plastic surgery unless related to disease or trauma deformity.
(22) Sliding mandibular osteotomies unless related to prognathism or micrognathism.
(23) Blepharoplasties when not related to a significant obstructive vision problem.
(24) Radial keratotomy.
(25) Miscellaneous procedures or modalities, including, but not limited to, the following:
(A) Autopsy.
(B) Cryosurgery for chloasma.
(C) Conray dye injection supervision.
(D) Day care or partial day care or partial hospitalization except when provided pursuant to 405 IAC 5-20.
(E) Formalized and predesigned rehabilitation programs, including, but not limited to, the following:
(i) Pulmonary.
(ii) Cardiovascular.
(iii) Work-hardening or strengthening.
(F) Telephone transmitter used for transtelephonic monitor.
(G) Telephone, or any other means of communication, consultation from one (1) doctor to another.
(H) Artificial insemination.
(I) Cognitive rehabilitation, except for treatment of traumatic brain injury.
(26) Ear piercing.
(27) Cybex evaluation or testing or treatment.
(28) High colonic irrigation.
(29) Services that are not prior authorized under the level-of-care methodology as required by 405 IAC 5-21.5.
(30) Amphetamines when prescribed for weight control or treatment of obesity.
(31) Under federal law, drug efficacy study implementation drugs not covered by Medicaid.
(32) All anorectics, except amphetamines, both legend and nonlegend.
(33) Physician samples.

(Office of the Secretary of Family and Social Services; 405 IAC 5-29-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3356, filed Sep 27, 1999, 8:55 a.m.: 23 IR 320; filed Sep 1, 2000, 2:16 p.m.: 24 IR 15; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 380; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 293. 405 IAC 5-30-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-1 Reimbursement restrictions

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

Sec. 1. Medicaid reimbursement is available for emergency and nonemergency transportation, subject to the following restrictions:
(1) Except when medical necessity for additional trips is demonstrated and documented through the prior authorization process, reimbursement is available for a maximum of twenty (20) one-way trips per ~~recipient,~~ **member,** per rolling twelve (12) month period of time. The following services are exempt from the numeric cap and do not require prior authorization, except as specified in subdivision (2):
(A) Emergency ambulance services.
(B) Transportation to or from a hospital for the purpose of an inpatient admission or discharge. This includes interhospital transfers when the ~~recipient~~ **member** has been discharged from one (1) hospital for the purpose of admission to another hospital.
(C) Transportation for ~~patients~~ **members** on renal dialysis or those residing in nursing homes.

(D) Accompanying parent or ~~recipient~~ **member** attendant, or both.
(E) Return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport.

(2) Prior authorization is required for all trips of fifty (50) miles or more one (1) way.

(3) Service must be for transportation to or from an Indiana Medicaid covered service, or both. The ~~recipient~~ **member** being transported for treatment must be present in the vehicle in order for Medicaid reimbursement to be available. Providers must comply with all applicable Medicaid documentation requirements, as set forth in provider manuals or bulletins, in effect on the date of service.

(4) Transportation must be unavailable from a non-Medicaid reimbursed source, with the exception of Medicaid payments for family member mileage. This source may include, but is not limited to, the following:
(A) A ~~recipient~~ **member** owned vehicle.
(B) A volunteer organization.
(C) Willing family or friends.

(5) Transportation must be the least expensive type of transportation available that meets the medical needs of the ~~recipient.~~ **member.**

(6) The ~~county~~ office ~~of family and children in the county in which the recipient resides~~ must authorize all in-state train, bus, or family member transportation services. The ~~recipient~~ **member** or a party acting on the ~~recipient's~~ **member's** behalf must make the request for any required authorization to the ~~county~~ office. For purposes of this rule, in-state includes out-of-state designated areas.

(7) When a ~~recipient~~ **member** needs airline, air ambulance, interstate transportation, or transportation services from a provider located out-of-state in a nondesignated area, the ~~county~~ office or the physician must forward the request for authorization by telephone or in writing to the contractor. Telephone requests must be followed up in writing. The request must include a description of the anticipated care and a brief description of the clinical circumstances necessitating the need for transportation by air or to another state, or both. The contractor will review the request. If authorized, the transportation provider will receive the authorization to arrange the transportation. Copies of the prior authorization decision are sent to the ~~recipient~~ **member** and the rendering provider.

(8) A provider is not entitled to Medicaid reimbursement in any amount that exceeds what the provider accepts as payment in full (including any coupon, cash discount, or other type of discount) for the same or equivalent services provided to any non-Medicaid customer.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3357; filed Sep 27, 1999, 8:55 a.m.: 23 IR 321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 294. 405 IAC 5-30-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-2 Copayments for transportation services

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

Sec. 2. In accordance with IC 12-15-6, a copayment will be required for transportation services as follows:

(1) The copayment shall be made by the ~~recipient~~ **member** and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the ~~recipient~~ **member** is liable.

(2) In accordance with 42 CFR 447.15, effective October 1, 1991, not including tertiary citations therein, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under this federal requirement, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

(3) The provider shall collect from the ~~recipient~~ **member** a copayment amount equal to the following:
(A) Fifty cents ($0.50) for services for which Medicaid pays ten dollars ($10) or less.
(B) One dollar ($1) for services for which Medicaid pays ten dollars and one cent ($10.01) to fifty dollars ($50).
(C) Two dollars ($2) for services for which Medicaid pays fifty dollars and one cent ($50.01) or more.
(D) No copayment will be required for an accompanying adult traveling with a minor ~~recipient~~ **member** or for an attendant.

(4) The following transportation services are exempt from the copayment requirement:
(A) Emergency ambulance services.
(B) Services furnished to individuals less than eighteen (18) years of age.

(C) Services furnished to pregnant women.
(D) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for ~~the mentally retarded,~~ **individuals with intellectual disabilities,** or other medical institutions.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3358; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 295. 405 IAC 5-30-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-3 Noncovered transportation services

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

Sec. 3. Medicaid reimbursement is not available for the following transportation services:
(1) One-way trips exceeding twenty (20) per ~~recipient,~~ **member,** per rolling twelve (12) month period of time, except when medical necessity for additional trips is demonstrated and documented through the prior authorization process. The services identified in section 1(1) of this rule are exempt from the numeric cap and do not require prior authorization, except as specified in section 1(2) of this rule.
(2) Trips of fifty (50) miles or more one (1) way unless prior authorization is obtained.
(3) The first thirty (30) minutes of waiting time for any type of Medicaid covered conveyance, including ambulance.
(4) Nonemergency transportation provided by any of the following:
(A) A volunteer with no vested or personal interest in the ~~recipient.~~ **member.**
(B) An interested individual or neighbor of the ~~recipient.~~ **member.**
(C) A case worker or social worker.
(5) Ancillary nonemergency transportation charges, including, but not limited to, the following:
(A) Parking fees.
(B) Tolls.
(C) ~~Recipient~~ **Member** meals or lodging.
(D) Escort meals or lodging.
(6) Disposable medical supplies, other than oxygen, when provided by a transportation provider.
(7) Transfer of durable medical equipment, either from the ~~recipient's~~ **member's** residence to place of storage, or from the place of storage to the ~~recipient's~~ **member's** residence.
(8) Charges for use of red lights and siren in emergency ambulance call.
(9) All interhospital transportation services, except when the ~~recipient~~ **member** has been discharged from one (1) hospital for the purpose of admission to another hospital.
(10) Delivery services for prescribed drugs, including transportation of a ~~recipient~~ **member** to or from a pharmacy to pick up a prescribed drug.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3358; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 296. 405 IAC 5-30-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-4 Prior authorization

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

Sec. 4. Prior authorization is required for the following transportation services:
(1) Train or bus services.
(2) Family member services.
(3) Airline or air ambulance and transportation services rendered by a provider located out-of-state in a nondesignated area.
(4) Transportation rendered by any provider to or from an out-of-state nondesignated area.
(5) Trips exceeding twenty (20) one-way trips per ~~recipient,~~ **member,** per rolling twelve (12) month period of time, except as specified in section 1 of this rule.
(6) Trips of fifty (50) miles or more one (1) way.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3359; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 297. 405 IAC 5-30-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-5 Ambulance services

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

Sec. 5. Medicaid reimbursement is available for medically necessary emergency and nonemergency ambulance services subject to the following:

(1) Medicaid will reimburse both basic and advanced life support emergency ambulance services; however, advanced life support ambulance services are covered only when such level of service is medically necessary, and a basic emergency ambulance is not appropriate due to the medical condition of the ~~recipient~~ **member** being transported.

(2) Medicaid reimbursement is available for specialized neonatal ambulance services used exclusively for interhospital transfers of high risk and premature infants only when the ~~recipient~~ **member** has been discharged from one (1) hospital for the purpose of admission to another hospital and only when such neonatal ambulances are recognized by emergency medical services.

(3) Ambulance services are subject to maximum allowable fees. Medicaid reimbursement is available for the following ambulance services:

(A) Loading fee.

(B) Loaded mileage, which shall be paid for each mile of the trip.

(C) Oxygen.

(D) Waiting time, except for the first thirty (30) minutes, and only when the trip exceeds fifty (50) miles one (1) way and prior authorization has been obtained from the Medicaid contractor.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3359; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 298. 405 IAC 5-30-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-6 Intrastate wheelchair/nonambulatory services

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

Sec. 6. Intrastate wheelchair/nonambulatory services are reimbursable when a ~~recipient~~ **member** must travel in a wheelchair to or from an Indiana Medicaid covered service. Wheelchair/nonambulatory services are subject to maximum allowable fees. Reimbursement is available as follows:

(1) Base rate means the flat fee paid by Medicaid for all trips, regardless of trip length.

(2) In addition to the base rate, mileage payments are available for loaded miles in excess of a specified number of miles as determined by the state.

(3) Waiting time is reimbursable only when the ~~recipient~~ **member** must travel fifty (50) miles or more one (1) way and prior authorization has been obtained from the Medicaid contractor. Waiting time is reimbursable only for those cases in which the vehicle is parked outside the provider of medical service awaiting the return of the ~~recipient~~ **member** to the vehicle. The first thirty (30) minutes of waiting time are not covered by Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3359; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 299. 405 IAC 5-30-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-7 Intrastate commercial ambulatory services

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-13-7-3; IC 12-15-6

Sec. 7. Intrastate commercial ambulatory services are reimbursable when an ambulatory ~~recipient~~ **member** must travel to or from an Indiana Medicaid covered service. Commercial ambulatory services are those services provided to ambulatory ~~recipients~~ **members** by any means other than the services described in sections 8 through 10 of this rule. This classification includes profit and not-for-profit entities using van, taxi, or bus type vehicles. Commercial ambulatory services are subject to maximum allowable fees. Reimbursement is available as follows:

(1) Taxi providers operating within their legal boundaries in accordance with state law whose rates are regulated by local ordinance must bill the lower of their metered or zoned rate, as established by local ordinance, or the maximum allowed rate.

(2) Taxi providers operating within their legal boundaries in accordance with state law whose rates are not regulated by local ordinance are reimbursed the lower of their submitted charge or a maximum allowable fee based on trip length.

(3) No additional mileage payments above the maximum rate are available for taxi services.

(4) Nontaxi commercial ambulatory service providers are reimbursed a base rate for all trips regardless of trip length, plus mileage payments for loaded miles in excess of a specified number of miles as determined by the state.

(5) The first thirty (30) minutes of waiting time is not covered by Medicaid. Waiting time is covered only when the ~~recipient~~ **member** must travel fifty (50) miles or more one (1) way and prior authorization has been obtained from the Medicaid contractor. Waiting time is reimbursable only for those cases in which the vehicle is parked outside the provider of medical service awaiting the return of the ~~recipient~~ **member** to the vehicle.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3359; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 300. 405 IAC 5-30-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-8 Reimbursement for additional passengers

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

Sec. 8. Medicaid reimbursement is available for second or subsequent passengers in a single vehicle at one-half (1/2) the base rate allowance for wheelchair/nonambulatory services and commercial ambulatory services when provided in such vehicles. No additional payment will be made for mileage or waiting time for second or subsequent passengers. Additional Medicaid reimbursement is not available for multiple passengers when the provider involved does not bill non-Medicaid customers for like services. Medicaid will not make additional payment for multiple passengers in ambulance or family member vehicles. The following are the circumstances under which providers may bill for multiple passengers in a single vehicle:

(1) When a minor ~~recipient~~ **member** is in need of medical services and an adult must accompany him or her, payment will be made under the commercial ambulatory services or nonambulatory services base code for the ~~recipient~~ **member** and under the appropriate multiple passenger code for the accompanying adult. Payment will not be made for the transportation of an individual to accompany a competent adult to obtain medical services.

(2) When an adult ~~recipient~~ **member** is in need of medical services and because of **his or her** condition must have an assistant to travel with him or her and/or stay with him **or her** in the place of medical service, the commercial ambulatory services or the nonambulatory services base code will be reimbursed for the ~~recipient~~ **member** and the accompanying multiple passenger code will be reimbursed for the assistant.

(3) When more than one (1) ~~recipient~~ **member** is transported simultaneously from the same county to the same vicinity for medical services, the full base code (commercial ambulatory services or nonambulatory services) will be reimbursed for the first ~~recipient,~~ **member,** plus mileage and waiting codes, where appropriate. Payment for the second and subsequent ~~recipients~~ **members** is available for one-half (1/2) the base rate allowance. Mileage and waiting codes may not be billed.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3360; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 301. 405 IAC 5-30-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-9 Reimbursement for family member transportation services

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 9. Family members enrolled as transportation providers under 405 IAC 5-4-3 are eligible for reimbursement for mileage only. Reimbursement is determined by the actual loaded mileage multiplied by the rate per mile established by the Indiana legislature for state employees. The ~~county~~ office ~~of family resources in which the recipient resides~~ must authorize all family member transportation. Notwithstanding all other provisions of this rule, beginning upon the later of the effective date of LSA Document #10-792 or June 27, 2011, and continuing through June 30, 2013, rates calculated under this section shall be reduced by ten percent (10%).

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3360; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 3:59 p.m.: 20110608-IR-405100792FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 302. 405 IAC 5-30-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-30-10 Reimbursement for other transportation services

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

Sec. 10. Medicaid reimbursement is available for other transportation services, including, but not limited to, intrastate bus or train transportation. Medicaid payment for other transportation services will be that fee usually and customarily charged the general public, subject to federal, state, or local law, rule, or ordinance. Intrastate bus or train services (including services provided in designated areas) require authorization by the ~~county~~ office, and interstate bus or train services require authorization from the contractor. Authorization may be given for use of monthly bus passes in situations where a ~~recipient~~ **member** has an ongoing medical need so that purchase of the bus pass is cost effective when compared to the cost of other modes of transportation. Such authorization shall be given only if the ~~recipient~~ **member** has agreed to the use of this mode of transportation. To be reimbursed, the bus or train company providing services must be enrolled as a ~~Medicaid~~ provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3360; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 303. 405 IAC 5-31-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-31-1 Reimbursement

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

Sec. 1. Medicaid reimbursement is available for nursing facility services provided by a licensed and certified nursing facility in accordance with 405 IAC 1-14.6 or 405 IAC 1-17 when rendered to a ~~Medicaid recipient~~ **member** whose level of care has been approved by the office. ~~or its designee.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3361; filed Sep 27, 1999, 8:55 a.m.: 23 IR 321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 304. 405 IAC 5-31-1.1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-31-1.1 "Nursing facility services" defined

Authority: 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. 1.1. As used in this rule, "nursing facility services" means services ordered by and under the direction of a physician, which can only be provided on an inpatient basis in a certified nursing facility that meets conditions of participation in 42 CFR 440.150, 42 CFR 440.155, and 42 CFR 483. ~~Recipients~~ **Members** requiring nursing facility level of care are those who do not require the degree of care and treatment that a hospital provides, but who, because of their mental or physical condition, require care and services above the level of room and board.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-1.1; filed Sep 27, 1999, 8:55 a.m.: 23 IR 321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 305. 405 IAC 5-31-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-31-4 Per diem services

Authority: 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. 4. Those services and products furnished by the facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with 405 IAC 1-14.6. The per diem rate for nursing facilities includes the following services:

(1) Room and board (room accommodations, all dietary services, and laundry services). The per diem rate includes accommodations for semiprivate rooms. Medicaid reimbursement is available for medically necessary private rooms. Private rooms will be considered medically necessary only under one (1) or both of the following circumstances:

(A) The ~~recipient's~~ **member's** condition requires isolation for health reasons, such as communicable disease.

(B) The ~~recipient~~ **member** exhibits behavior that is or may be physically harmful to self or others in the facility.

(2) Nursing care.

(3) The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients.

(4) Durable medical equipment (DME), and associated repair costs, routinely required for the care of patients, including, but not limited to:

(A) ice bags;
(B) bed rails;
(C) canes;
(D) walkers;
(E) crutches;
(F) standard wheelchairs;
(G) traction equipment; and
(H) oxygen and equipment and supplies for its delivery;

are covered in the per diem rate and may not be billed to Medicaid by the facility, an outside pharmacy, or any other provider. Nonstandard items of DME and associated repair costs that have received prior authorization must be billed to Medicaid directly by the DME provider. Facilities may not require ~~recipients~~ **members** to purchase or rent such equipment with their personal funds. DME purchased with Medicaid funds becomes the property of the office. ~~of Medicaid policy and planning.~~ The ~~county~~ office ~~of family and children~~ must be notified when the ~~recipient~~ **member** no longer needs the equipment.

(5) Medically necessary and reasonable therapy services, which include physical, occupational, respiratory, and speech pathology services.

(6) Transportation to vocational/habilitation service programs.

(7) The cost of both legend and nonlegend water products used for irrigation or humidification must be included in per diem reimbursement and must not be reimbursed through the pharmacy benefit. Water agents used alone (not intended to deliver a drug) for irrigation or humidification must be included in per diem reimbursement and must not be reimbursed through the pharmacy benefit.

(8) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis, by the member, nursing facility care staff, or by prescriber's order, as a part of routine care, as defined in ~~405 IAC 1-14.6-2(gg),~~ **405 IAC 1-14.6-2(ff),** must be included in the per diem reimbursement and must not be reimbursed by the pharmacy benefit.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3361; filed Sep 27, 1999, 8:55 a.m.: 23 IR 322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:35 a.m.: 26 IR 3633, eff on the first day of the calendar quarter following the thirtieth day after filing with the secretary of state; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)

SECTION 306. 405 IAC 5-31-4.5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-31-4.5 Per diem services, state nursing facility

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

Sec. 4.5. (a) Those services and products furnished by a state nursing facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with 405 IAC 1-17. The per diem rate for state nursing facilities includes the following services:

(1) Room and board:
  (A) room accommodations;
  (B) all dietary services; and
  (C) laundry services.
(2) Nursing care.
(3) The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients, is included in the nursing facility per diem.
(4) Durable medical equipment (DME), and associated repair costs, routinely required for the care of patients, including, but not limited to:
  (A) ice bags;
  (B) bed rails;
  (C) canes;
  (D) walkers;
  (E) crutches;
  (F) standard wheelchairs;
  (G) traction equipment; and
  (H) oxygen and equipment and supplies for its delivery;

are covered in the per diem rate and may not be billed to Medicaid by the facility, an outside pharmacy, or any other provider. Nonstandard items of DME and associated repair costs that have received prior authorization must be billed to Medicaid directly by the DME provider. Facilities may not require ~~recipients~~ **members** to purchase or rent such equipment with their personal funds. DME purchased with Medicaid funds becomes the property of the office. ~~of Medicaid policy and planning.~~ The ~~county~~ office ~~of family resources~~ must be notified when the ~~recipient~~ **member** no longer needs the equipment.

(5) Medically necessary ~~and reasonable~~ therapy services, which include:
  (A) physical;
  (B) occupational;
  (C) respiratory; and
  (D) speech pathology;

services.
(6) Dental services.
(7) Optometric services.
(8) Transportation services, except for emergency medical transportation services.
(9) Pharmaceutical products.
(10) The cost of both legend and nonlegend water products in all forms and for all uses.

(b) The services set out in subsection (a) provided to a Medicaid resident residing in a state nursing facility are reimbursed through the per diem rate except as follows:

(1) Hospital services rendered due to an acute illness or injury may be billed to Medicaid directly by the hospital. Individual exceptions to other medical care that must be rendered by practitioners outside the facility require prior authorization from the office.
(2) Dental services provided in the facility shall be included in the per diem rate. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization by the office. Dental services

prior authorized by the office must be billed to ~~the~~ Medicaid ~~program~~ directly by the outside dental provider. Admission of a ~~recipient~~ **member** to a hospital for the purpose of performing dental services requires prior authorization by the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-4.5; filed May 30, 2007, 8:22 a.m.: 20070627-IR- 405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 307. 405 IAC 5-31-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-31-5 Legend and prescription items

Authority: 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. 5. (a) All covered legend and nonlegend drugs must be prescribed by a physician. Facilities cannot require ~~recipients~~ **members** to purchase covered legend and nonlegend drug items with their personal funds.

(b) Anorectics (except amphetamines), both legend and nonlegend, are not covered by Medicaid. Amphetamines are not covered services for weight control or treatment of obesity.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3361; filed Sep 27, 1999, 8:55 a.m.: 23 IR 322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 308. 405 IAC 5-31-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-31-9 Prior authorization for services rendered outside the state nursing facility

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

Sec. 9. (a) Medical care rendered by practitioners outside the state nursing facility requires prior authorization.

(b) Prior authorization will not be given for medical services included in the per diem rate.

(c) Written evidence of physician involvement and personal patient evaluation in the progress notes and attached to the prior authorization form is required to document the medical necessity of the service.

(d) Prior authorization will include consideration of the following:
(1) Review of the properly completed Medicaid prior ~~review and~~ authorization request form substantiating both of the following:
(A) Medical necessity of the service.
(B) Explanation of why the service cannot be rendered at the facility.
(2) Review of criteria for the specific medical service requested as set forth in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-9; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 309. 405 IAC 5-34-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-1 Policy

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 1. (a) Medicaid reimbursement is available for hospice services subject to the limitations in this rule and

405 IAC 1-16. Hospice services consist of the following:

(1) Palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program patient during the final stages of the patient's terminal illness.

(2) Care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death.

(b) In order to receive Medicaid reimbursement for hospice services, a hospice provider must meet the requirements of section 2 of this rule.

(c) Notwithstanding any prior ~~approval~~ **authorization** by the office, the provision of all services shall comply with the Medicaid provider agreement, the appropriate provider manual applicable at the time such services were provided, all other Medicaid policy documents issued to providers, and any applicable state or federal statute or regulation.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-1; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 310. 405 IAC 5-34-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-2 Provider enrollment

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15; IC 16-25-3

Sec. 2. (a) In order to enroll as a hospice provider in ~~the Indiana~~ Medicaid ~~program,~~ a provider must submit a provider enrollment agreement as specified in 405 IAC 5-4. A separate provider agreement for hospice services must be completed even if the provider currently participates in ~~the Indiana~~ Medicaid ~~program~~ as a provider of another service.

(b) A hospice provider must be certified as a hospice provider in the Medicare program. A copy of the provider's Medicare Certification Letter from the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, must be submitted with the Medicaid provider enrollment agreement. The hospice provider who operates at more than one (1) location must provide a copy of the Medicare Certification Letter from CMS that demonstrates that the regional office has approved each additional office location to be Medicare-certified as a either a satellite office of the home office location or as a separate hospice with its unique Medicare provider number.

(c) The provider must comply with all state and federal requirements for Medicaid and Medicare providers in addition to the requirements in this section. The hospice and all hospice employees must be licensed in accordance with applicable federal, state, and local laws and regulations as required under federal regulations at 42 CFR 418.72 and Indiana state hospice licensure at IC 16-25-3.

(d) The hospice provider must designate an interdisciplinary group composed of individuals who are employees of the hospice and who provide or supervise care and services offered by the hospice provider. At a minimum, this group must include all of the following persons:

(1) A medical director, who must be a doctor of medicine or osteopathy.
(2) A registered nurse.
(3) A social worker.
(4) A pastoral or other counselor.

(e) The interdisciplinary group is responsible for the following:

(1) Participation in the establishment of the plan of care.
(2) Provision or supervision of hospice care and services.
(3) Review and updating of the plan of care.
(4) Establishment of policies governing the day-to-day provision of care and services.

(f) A hospice provider may not discontinue or diminish care provided to the Indiana ~~Medicaid recipient~~ **member** because of the ~~recipient's~~ **member's** source of payment.

(g) The provider must demonstrate respect for a ~~recipient's~~ **member's** rights by ensuring that the election of hospice services is based on the informed, voluntary consent of the ~~recipient~~ **member** or the ~~recipient's~~ **member's** representative.

(h) A hospice provider may discharge a ~~recipient~~ **member** from hospice services only if one (1) or more of the following occurs:
(1) The ~~recipient~~ **member** dies.
(2) The ~~recipient~~ **member** is determined to have a prognosis greater than six (6) months.
(3) The ~~recipient~~ **member** moves out of the hospice's service area.
(4) The safety of the ~~recipient,~~ **member,** other patients, or hospice staff is compromised.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 311. 405 IAC 5-34-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-3 Out-of-state providers

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 3. (a) Subject to the conditions in this section and section 2 of this rule, and any applicable state or federal licensing laws or regulations, an Indiana resident may receive hospice services from an out-of-state hospice provider if the provider is:
(1) located in a designated out-of-state city listed in 405 IAC 5-5-2(a); and
(2) enrolled in ~~the Indiana~~ Medicaid. ~~program.~~

(b) Prior authorization may be granted for an Indiana resident to receive hospice services from an out-of-state hospice provider not located in a designated out-of-state city if any one (1) of the criteria listed at 405 IAC 5-5-2(c) is met.

(c) Routine home care and continuous home care hospice services may be provided by out-of-state hospice providers to Indiana residents in their own home or in a nursing facility located in Indiana.

(d) Inpatient respite care and general inpatient care hospice services may be provided in an out-of-state hospice provider's facility.

(e) Routine home care and continuous home care hospice services cannot be provided to an Indiana resident in a nursing facility outside of Indiana, even if the nursing facility is located in an out-of-state designated city listed in 405 IAC 5-5-2(a).

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-3; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3636; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 312. 405 IAC 5-34-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-4 Hospice authorization and benefit periods

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 4. (a) Hospice services require Medicaid hospice authorization by the office or its contractor. Medicaid reimbursement is not available for hospice services furnished without authorization.

(b) To request hospice authorization for Medicaid-only eligible ~~recipients~~ **members** for each hospice benefit period, the provider must submit all of the following documentation on forms approved by the office:

(1) ~~Medicaid recipient~~ **Member** election statement.

(2) Medicaid physician certification.

(3) Medicaid plan of care.

(c) Dually-eligible Medicare/Medicaid ~~recipients~~ **members** residing in nursing facilities who elect hospice benefits must enroll simultaneously in the Medicare and Medicaid hospice benefits. To obtain hospice authorization, the hospice provider must submit the following forms as approved by the office for a one (1) time enrollment in the Medicaid hospice benefit:

(1) Medicaid Hospice Authorization Notice for Dually-Eligible Medicare/Medicaid Nursing Facility Residents.

(2) A copy of the hospice agency form reflecting the ~~recipient's~~ **member's** election of the Medicare hospice benefit. The form must reflect the signature of the ~~recipient~~ **member** or the ~~recipient's~~ **member's** representative and the date on which the form was signed.

The hospice provider is required to resubmit the forms described in this subsection when a dually-eligible Medicare/Medicaid hospice ~~recipient~~ **member** residing in a nursing facility reelects the Medicare and the Medicaid hospice benefit following a previous hospice revocation or hospice discharge.

(d) Hospice authorization is not required for the dually-eligible Medicare/Medicaid hospice ~~recipient~~ **member** residing at home as Medicare is reimbursing for the hospice care.

(e) Hospice authorization for the Medicaid-only hospice ~~recipient~~ **member** is available in the following consecutive benefit periods:

(1) One (1) period of ninety (90) days.

(2) A second period of ninety (90) days.

(3) An unlimited number of periods of sixty (60) days.

(f) Hospice authorization must be granted separately for each benefit period for the Medicaid-only hospice ~~recipient.~~ **member.** If benefit periods beyond the first ninety (90) days are necessary, then recertification on the physician certification form and an updated plan of care are required for authorization of the second and subsequent benefit periods. For the dually-eligible Medicare/Medicaid hospice ~~recipient~~ **member** residing in a nursing facility, hospice authorization is granted one (1) time at the time of enrollment in the Medicaid hospice benefit. Hospice authorization is not required for each hospice benefit period. Hospice authorization is required when the dually-eligible Medicare/Medicaid hospice ~~recipient~~ **member** residing in a nursing facility reelects the Medicare and the Medicaid hospice benefit following a previous hospice revocation or hospice discharge.

(g) In order to obtain authorization and reimbursement for hospice services, the provider must submit the documentation listed in this section to the office or its contractor within ten (10) business days of the effective date of the ~~recipient's~~ **member's** election, and within ten (10) business days of the beginning of the second and subsequent benefit periods if required under this section.

(h) When there is insufficient information submitted to render a hospice authorization decision or the documentation contains errors, a hospice authorization request will be suspended for thirty (30) days and the office or its contractor will request additional information from the provider. The provider must make the corrections and resubmit the proper documentation to the office or its contractor within thirty (30) calendar days after the additional information or correction is requested. If the provider fails to resubmit the documentation with the appropriate corrections within the thirty (30) day time period, the request for hospice authorization will be denied. If the provider submits additional documentation within thirty (30) days, but the documentation submitted does not provide sufficient information to render a decision, the office or its contractor may request additional information. The provider must submit the additional information within thirty (30) days after the additional information is requested. If the provider fails to submit the requested information within the additional thirty (30) days, or if the additional documentation does not provide sufficient information to render a decision, the request for hospice authorization will be denied.

(i) If a request for hospice authorization or supporting documentation are submitted after the time limits in this section, authorization may be granted only for services provided on or after the date that the request is received. Authorization for services furnished prior to the date of a request that does not comply with the time limits in this section may be granted only under the following circumstances:

(1) Pending or retroactive ~~recipient~~ **member** eligibility. The hospice authorization request must be submitted within twelve (12) months of the date of the issuance of the ~~recipient's~~ **member's** Medicaid card.

(2) The provider was unaware that the ~~recipient~~ **member** was eligible for services at the time services were rendered. Hospice authorization will be granted in this situation only if the following conditions are met:

(A) The provider's records document that the ~~recipient~~ **member** refused or was physically unable to provide the ~~recipient~~ **member** identification (RID or Medicaid) number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.

(C) The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered.

(3) Pending or retroactive approval of nursing facility level of care. The hospice authorization request must be submitted within one (1) year of the date nursing facility level of care is approved by the office.

(j) The office will rely on current professional guidelines, including the local Medicare medical review policies for hospice services, in making the hospice authorization determination.

(k) When approval for a benefit period has been granted, a hospice provider may manage a patient's care at the four (4) levels of care according to the medical needs determined by the interdisciplinary team and the requirements of the patient and the patient's family or primary caregivers. Changes in levels of care do not require prior ~~approval~~ **authorization** as long as these levels are rendered within a prior approved hospice benefit period.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3636; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 313. 405 IAC 5-34-4.1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-4.1 Appeals of hospice authorization determinations

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40-8
Affected: IC 12-15

Sec. 4.1. (a) ~~Medicaid recipients~~ **Members** may appeal the denial or modification of hospice authorization under 405 IAC 1.1.

(b) Any provider submitting a request for hospice authorization under this rule, which has been denied either in whole or in part, may appeal the decision under 405 IAC 1.1 after first submitting a request for reconsideration of the hospice authorization in accordance with the procedures set out in 405 IAC 5-7-2 and 405 IAC 5-7-3 for administrative reconsideration of prior authorization decisions.

(c) When there is insufficient information submitted to render a decision, or the documentation contains errors, a hospice authorization request will be suspended pursuant to section 4 of this rule, and the office or its contractor will request additional information from the provider. Suspension is not a final decision on the merits of the request and is not appealable. If the provider does not submit sufficient information within the time frames set out in section 4(h) of this rule, the request shall be denied. Denial is a final decision and may be appealed pursuant to subsections (a) and (b).

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4.1; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 314. 405 IAC 5-34-4.2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-4.2 Audit

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40-8
Affected: IC 12-15

Sec. 4.2. (a) The office ~~or its contractor~~ may conduct audits of hospice services, including services for which hospice authorization has been granted. Audit of hospice services shall include review of the medical record to determine the medical necessity of services based upon applicable current professional guidelines, including the local Medicare medical review policies for hospice services.

(b) If the office determines that hospice services for a member are not medically necessary, hospice authorization will be revoked for the dates during which hospice services did not meet medical necessity criteria for hospice care. Medicaid payment for hospice services is not available for services that the office determines are not medically necessary.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4.2; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 315. 405 IAC 5-34-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-5 Physician certification

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-15

Sec. 5. (a) In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing that the individual is terminally ill and expected to die from that illness within six (6) months. For a dually-eligible Medicaid/Medicare ~~recipient,~~ **member,** the hospice provider must comply with Medicare physician certification requirements, but the provider is not required to complete the Medicaid physician certification form or to submit the physician certification to the office. For a Medicaid-only hospice ~~recipient,~~ **member,** the Medicaid physician certification form must be completed and submitted to office as set out in this section.

(b) As required by federal regulations, the certification in subsection (a) must:
(1) be completed for the first period of ninety (90) days by the:
  (A) ~~the~~ medical director of the hospice program or the physician member of the hospice interdisciplinary group; and
  (B) ~~the recipient's~~ **member's** attending physician if the ~~recipient~~ **member** has an attending physician;
(2) be completed by one (1) of the physicians listed in subdivision (1)(A) for the second and subsequent periods;
(3) be signed and dated;
(4) identify the diagnosis that prompted the individual to elect hospice services;
(5) include a statement that the prognosis for life expectancy is six (6) months or less; and
(6) be submitted to the office ~~or its designee~~ within the time frames in subsection (c).

(c) The Medicaid physician certification must be submitted for the first period within ten (10) business days of the effective date of the Medicaid-only ~~recipient's~~ **member's** election. For the second and subsequent periods, the Medicaid physician certification must be submitted within ten (10) business days of the beginning of the benefit period.

(d) For the Medicaid-only hospice ~~recipient,~~ **member,** the Medicaid physician certification form must be included in the ~~recipient's~~ **member's** medical chart in the hospice agency and the ~~recipient's~~ **member's** medical chart in the nursing facility.

(e) Prior to the beginning of the ~~recipient's~~ **member's** third benefit period or one hundred eightieth day of hospice service and prior to each subsequent benefit period, a hospice physician or hospice nurse practitioner (NP) must have a face-to-face encounter with the ~~recipient~~ **member** to gather clinical findings to determine continued eligibility for hospice care and must attest in writing that such a visit took place. The face-to-face encounter must occur not more than thirty (30) calendar days prior to:

(1) the third benefit period recertification; and
(2) every subsequent recertification thereafter.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-5; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2381;readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 316. 405 IAC 5-34-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-6 Election of hospice services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-15

Sec. 6. (a) In order to receive hospice services, a ~~recipient~~ **member** must elect hospice services by filing an election statement with the hospice provider on forms specified by the office.

(b) For ~~recipients~~ **members** at least twenty-one (21) years of age, election of the hospice benefit requires the ~~recipient~~ **member** to waive Medicaid coverage for the following services:
(1) Other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness.
(2) Services provided by another provider ~~which~~ that are equivalent to the care provided by the elected hospice provider.
(3) Hospice services other than those provided by the elected hospice provider or its contractors.

(c) For ~~recipients~~ **members** less than twenty-one (21) years of age who elect the hospice benefit, the ~~recipient~~ **member** may receive concurrent curative care services in conjunction with hospice services for the terminal illness. This allows the ~~recipient~~ **member** or the ~~recipient's~~ **member's** representative to elect the hospice benefit, without forgoing any curative service the ~~recipient~~ **member** is entitled to under Medicaid for treatment of the terminal illness.

(d) The ~~recipient~~ **member** or ~~recipient's~~ **member's** representative may designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual may not designate an effective date that is earlier than the date of election.

(e) For Medicaid-only hospice ~~recipient,~~ **member,** the Medicaid election form must be submitted to the office ~~or its designee~~ along with the Medicaid physician's certification required by section 5 of this rule when hospice services are initiated. It is not necessary to submit the Medicaid election form for the second and subsequent benefit periods unless the ~~recipient~~ **member** has revoked the election and wishes to reelect hospice care.

(f) For the dually-eligible Medicare/Medicaid hospice ~~recipient~~ **member** residing in the nursing facility, the hospice agency election form reflecting the Medicare hospice election date and the ~~recipient's~~ **member's** signature must be submitted with the Medicaid hospice authorization form for dually-eligible Medicare/Medicaid nursing facility residents. It is not necessary to submit the Medicare election form for the second and subsequent benefit periods unless the ~~recipient~~ **member** has revoked the election and wishes to reelect hospice care under the Medicare and Medicaid hospice benefits.

(g) In the event that a ~~recipient~~ **member** or the ~~recipient's~~ **member's** representative wishes to revoke the election of hospice services, the following apply:
(1) The individual must file a hospice revocation statement on a form approved by the office. The form includes a signed statement that the individual revokes the election of Medicaid hospice services for the remaining days in the benefit period. The form must specify the date that the revocation is to be effective, if later than the date the form is signed by the individual or representative. An individual or representative may not designate an effective date earlier than the date that the revocation is made.
(2) A ~~recipient~~ **member** may elect to receive hospice care intermittently rather than consecutively over the benefit periods.
(3) If a ~~recipient~~ **member** revokes hospice services during any benefit period, time remaining on that benefit

period is forfeited.
(4) The revocation form must be completed for Medicaid-only hospice ~~recipients~~ **members** as well as dually-eligible Medicare/Medicaid hospice ~~recipients~~ **members** residing in nursing facilities. The hospice provider must submit this form to the office. ~~or its designee.~~
(5) The Medicaid hospice revocation form must be included in the ~~recipient's~~ **member's** medical chart in the hospice agency. If the Medicaid hospice ~~recipient~~ **member** resides in a nursing facility, the Medicaid hospice revocation form must be included in the ~~recipient's~~ **member's** nursing facility medical chart as well.

(h) A ~~recipient~~ **member** or a ~~recipient's~~ **member's** representative may change hospice providers once during any benefit period. This change does not constitute a revocation of services. The following apply when a ~~recipient~~ **member** changes hospice providers:
(1) To change the designation of hospice programs, the individual or the individual's representative must complete the Medicaid Hospice Provider Change Request Between Indiana Hospice Providers Form or other form designated by the office for this purpose. This form is required for the Medicaid-only hospice ~~recipient~~ **member** and the dually-eligible Medicare/Medicaid hospice member residing in the nursing facility. The original provider must submit this form to the office. ~~or its designee.~~
(2) The Medicaid Hospice Provider Change Request Between Indiana Hospice Providers Form, or other form designated by the office for this purpose, must be included in the ~~recipient's~~ **member's** medical chart in the hospice agency. If the Medicaid hospice ~~recipient~~ **member** resides in a nursing facility, this form must be included in the ~~recipient's~~ **member's** nursing facility chart. This documentation requirement is for the Medicaid-only hospice member as well as the dually-eligible Medicare/Medicaid hospice member residing in a nursing facility.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-6; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2381;readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3639; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 317. 405 IAC 5-34-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-7 Plan of care

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-15

Sec. 7. (a) When an eligible ~~recipient~~ **member** elects to receive services from a certified hospice provider, the provider shall develop a plan of care. For the Medicaid-only hospice ~~recipients,~~ **members,** the provider must submit the Medicaid plan of care form to the office or the office's contractor with the Medicaid physician certification and the Medicaid election statement. For ~~recipients~~ **members** less than twenty-one (21) years of age concurrently receiving hospice and curative care services, the providers rendering those services must submit an updated coordinated plan of care, including delineation of hospice and curative care services, to the office or the office's contractor.

(b) In developing the plan of care, the provider must comply with the following procedures:
(1) The interdisciplinary team member who drafts the plan must confer with at least one (1) other member of the interdisciplinary team.
(2) One (1) of the conferees must be a physician or nurse, and all other team members must review the plan of care.
(3) All services stipulated within the plan of care must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.
(4) For the Medicaid-only hospice ~~recipient,~~ **member,** the Medicaid hospice plan of care must be included in the ~~recipient's~~ **member's** medical chart at the hospice agency. If the Medicaid-only ~~recipient~~ **member** resides in a nursing facility, the Medicaid plan of care must also be included in the ~~recipient's~~ **member's** nursing facility medical chart.
(5) For the dually-eligible Medicare/Medicaid hospice ~~recipient~~ **member** residing in a nursing facility, a coordinated plan of care prepared and agreed upon by the hospice and nursing facility must be included in the ~~recipient's~~ **member's** nursing facility medical chart.
(6) For ~~recipients~~ **members** less than twenty-one (21) years of age concurrently receiving hospice and curative care services, the Medicaid plan of care must include the information identified previously in this section, and a coordinated plan of care must be prepared and agreed upon by the hospice interdisciplinary

team and the provider or providers rendering the curative care services. The plan of care must include the following:

(A) An assessment of the ~~recipient's~~ **member's** needs.

(B) The curative care and hospice services the ~~recipient~~ **member** is receiving along with the scope and frequency of these services and the manner in which the services and assessments are coordinated.

The plan of care must be included in the ~~recipient's~~ **member's** medical charts of both the hospice and curative care providers. The advanced directive, if applicable, must be included in the ~~recipient's~~ **member's** medical charts of both the hospice and curative care providers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-7; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3640; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 318. 405 IAC 5-34-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-8 Covered services

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 8. Services covered within the hospice per diem reimbursement rates include the following:

(1) Nursing care provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker who has at least a bachelor's degree and who is working under the supervision of a physician.

(3) Physicians' services provided by the medical director or physician member of the interdisciplinary team that may be characterized as follows:

(A) General supervisory services.

(B) Participation in the establishment of the plan of care.

(C) Supervision of the plan of care.

(D) Periodic review.

(E) Establishment of governing policies.

(4) ~~Counselling~~ **Counseling** services provided to the ~~recipient~~ **member** and the ~~recipient's~~ **member's** family or other person caring for the ~~recipient.~~ **member.**

(5) Short term inpatient care provided in a hospice inpatient unit, participating hospital, or nursing home, subject to the limits in 405 IAC 1-16-3.

(6) Medical appliances and supplies, including palliative drugs, that are related to the palliation or management of the ~~recipient's~~ **member's** terminal illness.

(7) Home health services furnished by qualified aides.

(8) Homemaker services that assist in providing a safe and healthy environment.

(9) Physical, occupational therapy, and speech-language pathology services provided for purposes of symptom control.

(10) Inpatient respite care, subject to the limitations in 405 IAC 1-16-2.

(11) Room and board for ~~recipients~~ **members** who reside in long term care facilities, as set out in 405 IAC 1-16-4.

(12) Any other item or service specified in the ~~recipient's~~ **member's** plan of care, if the item or service is a covered service under the Medicare program.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-8; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 319. 405 IAC 5-34-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-9 Levels of care

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 9. (a) Covered hospice services will be delivered and reimbursed at one (1) of four (4) levels, the utilization of which shall be determined by the hospice provider within the context of the overall utilization and

reimbursement limitations contained in this rule and 405 IAC 1-16.

(b) The levels of care are as follows:
(1) Routine home hospice care.
(2) Continuous home hospice care.
(3) Inpatient respite care.
(4) General inpatient hospice care.

(c) When routine home care and continuous home care are furnished to a ~~recipient~~ **member** who resides in a nursing facility, the nursing facility is considered the ~~recipient's~~ **member's** home.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-9; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 320. 405 IAC 5-34-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-10 Location of care

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 10. (a) The usual home of the hospice ~~recipient~~ **member** determines the location of care for that ~~recipient.~~ **member.** For purposes of this rule and 405 IAC 1-16, hospice location of care will be categorized according to one (1) of two (2) locations.

(b) Private home location of care applies if the ~~recipient~~ **member** usually lives in his or her private home.

(c) Nursing facility location of care applies if the ~~recipient~~ **member** usually lives in a nursing facility.

(d) The additional room and board amount available for nursing facility residents under 405 IAC 1-16-4 is available only if the hospice ~~recipient~~ **member** meets the criteria for nursing facility level of care under 405 IAC 1-3.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-10; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 321. 405 IAC 5-34-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-11 Prior authorization for nonhospice services

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 11. (a) Except as provided in subsection (b), prior authorization is required for any Medicaid-covered service not related to the hospice ~~recipient's~~ **member's** terminal condition if prior authorization is otherwise required under this article.

(b) Notwithstanding any other provision of this article, prior authorization is not required for the following services when provided to hospice patients:
(1) Pharmacy services, for conditions not related to the patient's terminal condition. Pharmacy services related to the patient's terminal condition do not require prior authorization because they are included in the hospice per diem.
(2) Dental services.
(3) Vision care services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-11; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2383;

readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 322. 405 IAC 5-34-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-12 Reservation of beds for hospice members in nursing facilities

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 12. (a) Although it is not mandatory for providers to reserve beds, Medicaid will reimburse for reserving nursing facility beds for hospice ~~recipients~~ **members** at one-half (1/2) the room and board payment provided that the criteria as set out in this section are met.

(b) Hospitalization must be ordered by the hospice physician for treatment of an acute condition that cannot be treated in the nursing facility by the hospice provider. The maximum length of time allowed for payment of a reserved bed for a single hospital stay is fifteen (15) days.

(c) A leave of absence must be for therapeutic reasons, as prescribed by the hospice attending physician and as indicated in the hospice ~~recipient's~~ **member's** plan of care. The maximum length of time allotted for therapeutic leave in any calendar year is limited to eighteen (18) days, which need not be consecutive.

(d) Although prior authorization by the office is not required to reserve a bed, the hospice ~~recipient's~~ **member's** physician's order for the hospitalization or therapeutic leave must be on file in the nursing facility.

(e) In no instance will Medicaid reimburse a nursing facility for reserving nursing facility beds for hospice ~~Medicaid recipients~~ **members** when the nursing facility has an occupancy rate of less than ninety percent (90%). For purposes of this rule, the occupancy rate shall be determined by dividing the total number of residents in licensed beds, excluding residential beds, in the nursing facility taken from the midnight census as of the day that a Medicaid hospice ~~recipient~~ **member** takes a leave of absence, by the total number of licensed nursing facility beds, excluding residential beds.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-12; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2383; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:34 p.m.: 25 IR 2476; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 323. 405 IAC 5-36-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-36-1 DSMT policy; definitions

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 27-8-14.5-6

Sec. 1. (a) Reimbursement is available for diabetes self management training, ~~(hereinafter "DSMT"),~~ as defined in this rule and when provided in accordance with all applicable provisions of this rule, provider bulletins, provider manuals, and the provider agreement.

(b) As used in this rule, "DSMT" means diabetes self management training and is comprised of those services provided in accordance with IC 27-8-14.5-6. These services are intended to enable the ~~patient~~ **member** to, or enhance the ~~patient's~~ **member's** ability to, properly manage ~~their~~ **the member's** diabetic condition, thereby optimizing ~~their~~ **the member's** own therapeutic regimen. Examples of DSMT include, but are not limited to, the following:

(1) Instruction regarding the diabetic disease state, nutrition, exercise, and activity.
(2) Medications counseling.
(3) Blood glucose self-monitoring training.
(4) Foot, skin, and dental care.
(5) Behavior change strategies and risk factor reduction.

(6) Preconception care, pregnancy, and gestational diabetes.
(7) Accessing community health care systems and resources.

(c) As used in this rule, "health care professionals" means the following:
(1) Chiropractors.
(2) Dentists.
(3) Health facility administrators.
(4) Physicians.
(5) Nurses.
(6) Optometrists.
(7) Pharmacists.
(8) Podiatrists.
(9) Environmental health specialists.
(10) Audiologists.
(11) Speech-language pathologists.
(12) Psychologists.
(13) Hearing aid dealers.
(14) Physical therapists.
(15) Respiratory therapists.
(16) Occupational therapists.
(17) Social workers.
(18) Marriage and family therapists.
(19) Physician assistants.
(20) Athletic trainers.
(21) ~~Dieticians.~~ **Dietitians.**

(d) As used in this rule, a "unit" of DSMT service means a time period of fifteen (15) minutes.

(Office of the Secretary of Family and Social Services; 405 IAC 5-36-1; filed Sep 27, 1999, 8:55 a.m.: 23 IR 323; errata filed Dec 9, 1999, 1:17 p.m.: 23 IR 814; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 324. 405 IAC 5-36-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-36-3 Limitations on coverage of DSMT

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 27-8-14.5

Sec. 3. (a) Coverage of DSMT is limited to sixteen (16) units of DSMT per ~~recipient,~~ **member,** per rolling calendar year without prior authorization. Additional units of DSMT may be authorized via the prior authorization process.

(b) Coverage of DSMT is limited to the following clinical circumstances:
(1) Receipt of a diagnosis of diabetes.
(2) Receipt of a diagnosis that represents a significant change in the patient's symptoms or condition.
(3) Re-education or refresher training.

(Office of the Secretary of Family and Social Services; 405 IAC 5-36-3; filed Sep 27, 1999, 8:55 a.m.: 23 IR 323; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 325. 405 IAC 5-37-3, PROPOSED TO BE AMENDED AT 20160203-IR-405140338PRA, SECTION 3, IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-37-3 Tobacco dependence counseling

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 3. (a) Reimbursement is available for tobacco dependence counseling services rendered by licensed practitioners under applicable Indiana law participating in ~~the Indiana~~ Medicaid ~~program~~ and listed in subsection (c). ~~Tobacco dependence counseling must be offered corresponding to the receipt of a legend or nonlegend drug intended to reduce an individual's dependence on tobacco products.~~

(b) A prescription for tobacco dependence products serves as documentation that the prescribing practitioner has prescribed or obtained assurance from the patient that counseling occurs corresponding to the receipt of tobacco dependence products.

(c) The following may provide tobacco dependence counseling services when prescribed by a practitioner within the scope of his or her license under Indiana law and within the limitations of this rule:

(1) A physician.
(2) A physician's assistant.
(3) A nurse practitioner.
(4) A registered nurse.
(5) A psychologist.
(6) A pharmacist.
(7) A dentist.
(8) An optometrist
(9) A clinical social worker.
(10) A marital and family counselor.
(11) A mental health counselor.
(12) A licensed clinical addictions counselor.

(Office of the Secretary of Family and Social Services; 405 IAC 5-37-3; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 380; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 326. 405 IAC 5-38-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-38-4 Limitations

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 4. Telemedicine shall be limited by the following conditions:

(1) The patient must:
  (A) be physically present at the spoke site; and
  (B) participate in the visit.
(2) The physician or practitioner who will be examining the patient from the hub site must determine if it is medically necessary for a medical professional to be at the spoke site. Separate reimbursement for a provider at the spoke site is payable only if that provider's presence is medically necessary. Adequate documentation must be maintained in the patient's medical record to support the need for the provider's presence at the spoke site during the visit. Such documentation is subject to postpayment review. If a health care provider's presence at the spoke site is medically necessary, billing of the appropriate evaluation and management code is permitted.
(3) Reimbursement for telemedicine services is available to the following providers regardless of the distance between the provider and ~~recipient:~~ **member:**
  (A) Federally qualified health centers.
  (B) Rural health clinics.
  (C) Community mental health centers.
  (D) Critical access hospitals.
(4) Reimbursement for telemedicine services for all other eligible providers is available only when the hub and spoke sites are greater than twenty (20) miles. Adequate documentation must be maintained as service is subject to postpayment review.
(5) Store and forward technology is not reimbursable by Medicaid. The use of store and forward technology is permissible as defined under section 2(4) of this rule.
(6) The following service or provider types may not be reimbursed for telemedicine:

(A) Ambulatory surgical centers.
(B) Outpatient surgical services.
(C) Home health agencies or services.
(D) Radiological services.
(E) Laboratory services.
(F) Long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled.
(G) Anesthesia services or nurse anesthetist services.
(H) Audiological services.
(I) Chiropractic services.
(J) Care coordination services.
(K) DME, medical supplies, hearing aids, or oxygen.
(L) Optical or optometric services.
(M) Podiatric services.
(N) Services billed by school corporations.
(O) Physical or speech therapy services.
(P) Transportation services.
(Q) Services provided under a Medicaid waiver.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-4; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)

SECTION 327. THE FOLLOWING ARE REPEALED: 405 IAC 5-2-2; 405 IAC 5-2-4; 405 IAC 5-2-5; 405 IAC 5-2-8; 405 IAC 5-2-11; 405 IAC 5-2-14; 405 IAC 5-2-23; 405 IAC 5-2-25.

Notice of Public Hearing

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