ARTICLE 5. MEDICAID SERVICES

Rule 1. General Provisions

405 IAC 5-1-1 Intent and purpose

Authority: IC 12-8-6-5; 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 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 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 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).

(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)

405 IAC 5-1-2 Nondiscrimination

Authority: IC 12-8-6-5; 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)*

405 IAC 5-1-3 Freedom of choice of provider

Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-1-4 Solicitation of services

Authority: IC 12-8-6-5; 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, 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, 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 to receive a service that the recipient 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)*

405 IAC 5-1-5 Global fee billing; codes

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

Sec. 5. (a) Providers must submit one (1) billing for a related group of procedures and services provided to a recipient.

(b) The Centers for Medicare and Medicaid Service's Common Procedure Coding System (HCPCS) and International Classification of Diseases 9th Revision Clinical Modification (ICD-9-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.

(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)*

405 IAC 5-1-6 New or experimental product, service, or technology

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

Sec. 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 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)*

Rule 2. Definitions

405 IAC 5-2-1 Applicability

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

Sec. 1. The definitions in this rule apply throughout this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-1; 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)*

405 IAC 5-2-2 "ADA" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. "ADA" means American Dental Association. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-2; 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)*

405 IAC 5-2-3 "Attending or primary physician" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. "Attending or primary physician" means the physician who is providing specialized or general medical care to the Medicaid recipient. *(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)*

405 IAC 5-2-4 "Contractor" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-30

Sec. 4. "Contractor" means that entity which makes payment to Medicaid providers under a contract with the office pursuant to IC 12-15-30. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-4; 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)*

405 IAC 5-2-5 "County office of family and children", "county office", or "OFC" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-7-2-45; IC 12-13; IC 12-15

Sec. 5. "County office of family and children", "county office", or "OFC" means that agency located in each county of Indiana that fulfills the duties set out in IC 12-13. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-5; 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)*

405 IAC 5-2-6 "Covered service" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-5

Sec. 6. "Covered service" means a service provided by a Medicaid provider for a Medicaid recipient 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)*

405 IAC 5-2-7 "CPT" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-5

Sec. 7. "CPT" means current procedural terminology. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-7;*

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)

405 IAC 5-2-8 "DRG" defined

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

Sec. 8. "DRG" means diagnosis related group. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-8; 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)*

405 IAC 5-2-9 "Emergency service" defined

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

Sec. 9. "Emergency service" means a service provided to a Medicaid recipient 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)

405 IAC 5-2-10 "EPSDT" defined

Authority: IC 12-8-6-5; 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. 10. "EPSDT" means early and periodic screening, diagnostic, and treatment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-10; 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)*

405 IAC 5-2-10.1 "Hospice" defined

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 10.1. "Hospice" means a person or health care provider who owns or operates a hospice program or facility, or both, that uses an interdisciplinary team directed by a licensed physician to provide a program of planned and continuous care for hospice program patients and their families. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-10.1; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-2-10.2 "Hospice program" defined

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 10.2. "Hospice program" means a specialized form of interdisciplinary health care that is designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-10.2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-2-11 "Indiana Medicaid program" or "Medicaid" defined
Authority: IC 12-8-6-5; 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. 11. "Indiana Medicaid program" or "Medicaid" means that program described under IC 12-15 and this title, in which the office, through its fiscal contractor, makes payments to Medicaid providers for covered services provided to Medicaid recipients. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-11; 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)*

405 IAC 5-2-12 "Inpatient services" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. "Inpatient services" means only those services provided to a recipient while the recipient 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)*

405 IAC 5-2-13 "ICD-9-CM" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 13. "ICD-9-CM" means International Classification of Diseases–9th Revision–Clinical Modification. *(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)*

405 IAC 5-2-14 "HCPCS" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 14. "HCPCS" means Health Care Financing Administration's Procedure Coding System. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-14; 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)*

405 IAC 5-2-15 "Level of care" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 15. "Level of care", in an inpatient hospital setting, means the reimbursement methodology used to pay providers for the services rendered, including DRG, 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)*

405 IAC 5-2-16 "Medical policy" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 16. "Medical policy" means those parameters for coverage of and reimbursement for services and supplies furnished to recipients 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)*

405 IAC 5-2-17 "Medically reasonable and necessary service" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 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)

405 IAC 5-2-18 "Office" defined
Authority: IC 12-8-6-5; 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. *(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)*

405 IAC 5-2-19 "Outpatient services" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 19. "Outpatient services" means those services provided to a recipient 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)*

405 IAC 5-2-20 "Prior authorization" or "prior approval" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 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. *(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)*

405 IAC 5-2-21 "Provider" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 21. "Provider" means an individual, state or local agency, or corporate or business entity that meets the requirements of 405 IAC 5-5. *(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)*

405 IAC 5-2-22 "Provider agreement" or "provider certification agreement" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 22. "Provider agreement" or "provider certification agreement" means a contract 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. *(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)*

405 IAC 5-2-23 "Recipient" defined
Authority: IC 12-8-6-5; 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. 23. "Recipient" means an individual who has been determined by the office or the county office to be eligible for payment of medical or remedial services pursuant to IC 12-15. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-23; 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)*

405 IAC 5-2-24 "Reimbursement" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 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. *(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)*

405 IAC 5-2-25 "RVU" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 25. "RVU" means relative value unit. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-25; 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)*

Rule 3. Prior Authorization

405 IAC 5-3-1 Prior authorization; generally
Authority: IC 12-8-6-3; IC 12-8-6-5; 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)*

405 IAC 5-3-2 Prior authorization by telephone

Authority: IC 12-8-6-3; IC 12-8-6-5; 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)

405 IAC 5-3-3 Prior authorization based on false information

Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 3. Services authorized on the basis of false information supplied by the provider or the provider's agent that the provider or the provider's agent knew or should have reasonably known to be false are not reimbursable. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-3; 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)*

405 IAC 5-3-4 Audit

Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 4. Retrospective audit shall include postpayment review of the medical record to determine the medical necessity of service as defined in this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; 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)*

405 IAC 5-3-5 Written requests for prior authorization; contents

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 original signature, or a copy of the original signature (signature stamps are also acceptable) of the provider.
(3) Diagnosis and related information (ICD-9-CM code).
(4) Services or supplies requested with appropriate CPT, HCPCS, or ADA 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.

(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)

405 IAC 5-3-6 Telephone requests for prior authorization; contents

Authority: IC 12-8-6-3; IC 12-8-6-5; 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.
(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 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.

(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)

405 IAC 5-3-7 Determination of recipient eligibility
Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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)*

405 IAC 5-3-8 Limitations
Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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)*

405 IAC 5-3-9 Prior authorization after services have begun
Authority: IC 12-8-6-3; IC 12-8-6-5; 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 eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the recipient'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 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 refused or was physically unable to provide the recipient 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)

405 IAC 5-3-10 Providers who may submit prior authorization requests
Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 10. Prior authorization requests may be submitted by any of the following:

(1) Doctor of medicine.

(2) Doctor of osteopathy.
(3) Dentist.
(4) Optometrist.
(5) Podiatrist.
(6) Chiropractor.
(7) Psychologist endorsed as a health service provider in psychology (HSPP).
(8) Home health agency.
(9) Hospitals.
(10) For drugs subject to prior authorization, any provider with prescriptive authority under Indiana law.

Requests from other provider types will not be accepted except for transportation services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1613; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-3-11 Criteria for prior authorization

Authority: IC 12-8-6-3; IC 12-8-6-5; 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)

405 IAC 5-3-12 Prior authorization; exceptions

Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
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 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 physician determines that an inpatient hospital setting is no longer necessary, but that Medicaid covered services should continue after the recipient 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 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.

(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)

405 IAC 5-3-13 Services requiring prior authorization

Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-15

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) Other drugs as specified in accordance with 405 IAC 5-24-8.5.
(18) Psychiatric inpatient admissions, including admissions for substance abuse.
(19) Rehabilitation inpatient admissions.
(20) Assertive community treatment intensive case management as provided under 405 IAC 5-21-1.
(21) Orthodontic procedures for members under twenty-one (21) years of age for cases of craniofacial deformity or cleft palate.
(22) Genetic testing for detection of cancer of the breast or breasts or ovaries.
(23) Community mental health rehabilitation services.
(24) As otherwise specified in this article.

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.

(b) 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)*

405 IAC 5-3-14 Prior authorization decision; time limit

Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
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 ten (10) working 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)*

Rule 4. Provider Enrollment

405 IAC 5-4-1 Enrollment of providers

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-10-2; IC 12-15-11

Sec. 1. (a) In order to receive reimbursement under the Indiana Medicaid program, a provider must be enrolled to participate as a Medicaid provider. A provider is enrolled to participate in Medicaid when all of the following conditions have been met:

(1) The provider is duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to state or federal law, or otherwise authorized by the office.

(2) The provider has submitted an application to participate in the Indiana Medicaid program and completed such forms as may be required by the department.

(3) The provider has signed and returned a Medicaid provider agreement.

(4) The provider has received a provider number from the Medicaid contractor.

(b) Out-of-state institutional or individual providers must be duly certified, licensed, registered, or authorized as required by the state in which the provider is located and must fulfill the conditions listed in subsection (a)(2) through (a)(4) before receiving any Indiana Medicaid payment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-4-1; 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)*

405 IAC 5-4-2 Provider agreement requirements for transportation services

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

Sec. 2. (a) The office will enter into a Medicaid transportation provider agreement only with a distinct transportation business entity which makes transportation services available to the general public and whose primary business function is the provision of transportation services. This requirement does not apply to transportation providers who provide only ambulance or family member transportation services. All providers must complete an Indiana Medicaid provider agreement. In addition, providers must satisfy the specific requirements in this section.

(b) With respect to ambulance service, in accordance with IC 16-1-39 *[IC 16-1 was repealed by P.L.2-1993, SECTION 209, effective April 20, 1993.]*, vehicles and staff that provide emergency services must be certified by the emergency medical services commission to be eligible for Medicaid reimbursement for transports involving either advanced life support or basic life support services that are emergency in nature. Failure to maintain the emergency medical services commission certification on all vehicles involved in transporting Medicaid recipients will result in termination of the Medicaid provider agreement.

(c) Common transportation carriers except for taxicab and not-for-profit transportation entities, in order to be eligible to participate as providers, must continuously comply with all state statutes, rules, and local ordinances governing public transportation. In addition, each provider applicant or enrolled provider must submit proof of, and maintain throughout its period of participation, the following:

(1) Certification by the Indiana motor carrier authority.

(2) Insurance coverage as required by the Indiana motor carrier authority.

(3) Appropriate and valid drivers' licenses for all drivers.

(d) Taxicab transportation entities, in order to be eligible to participate as providers, must continuously comply with all federal and state statutes, rules, and local ordinances governing their operation. In addition, each provider applicant or enrolled provider must submit proof of and maintain throughout its period of participation the following:

(1) Written acknowledgement by local or county officials of whether there are existing ordinances governing taxi services and written verification from local or county officials that taxicab services operating in the local vicinity are in compliance with those ordinances.

(2) Livery insurance as indicated by existing local ordinances, or in the absence of such ordinances, a minimum of twenty-five thousand dollars/fifty thousand dollars ($25,000/$50,000) public livery insurance covering all vehicles used in the business.

(3) Appropriate and valid drivers' licenses for all drivers.

(e) Not-for-profit transportation entities, in order to be eligible as providers, must continuously comply with all federal and

state statutes, rules, and local ordinances governing their operation. In addition, each provider applicant or enrolled provider must submit proof of, and maintain throughout its period of participation, the following:

(1) An acknowledgement from state or federal officials of their status as a not-for-profit entity.

(2) A minimum of five hundred thousand dollars ($500,000) of combined single limit commercial automobile liability insurance.

(3) Appropriate and valid drivers' licenses for all drivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-4-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3307; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-4-3 Enrollment of a family member as a transportation provider

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

Sec. 3. When a recipient must make frequent trips to medical services and that travel creates undue financial hardship for the family, a family member may be enrolled as a Medicaid transportation provider. If no family member is available to provide this service, a close associate, or the recipient, if medically able, may be enrolled as a family member transportation provider. When a family member is enrolled as a transportation provider, that individual may provide services only to the designated recipient, and those services are subject to county OFC prior authorization. To be eligible to participate in Medicaid as a family member transportation provider, the individual must meet the following requirements:

(1) Possess a valid driver's license as required by state law.

(2) Possess coverage of the minimum amount of automobile insurance as required by state law.

(3) Utilize as the vehicle for transporting family members, only a vehicle which has been duly licensed and registered.

(4) Be enrolled as a family member Medicaid transportation provider. The county OFC, on behalf of the family member, must submit the enrollment request to the office or its designee for its approval.

(5) Each request for enrollment of a family member provider should include the following information:

(A) The recipient's name and Medicaid number.

(B) The name, address, and relationship of the family member provider.

(C) A description of the circumstances surrounding the request.

(D) A statement of the financial impact on the family as a result of providing transportation services to the recipient.

(E) The desired effective date for the enrollment of the family member as a transportation provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-4-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3307; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-4-4 Enrollment of a nursing facility; conditions for reimbursement for certified beds (Voided)

Sec. 4. *(Voided by P.L.158-2007, SECTION 3, effective May 4, 2007.)*

Rule 5. Out-of-State Services

405 IAC 5-5-1 Out-of-state services; general

Authority: IC 12-8-6-5; 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. Medicaid reimbursement is available for the following services provided outside Indiana:

(1) Acute general hospital care.

(2) Physician services.

(3) Dental services.

(4) Pharmacy services.

(5) Transportation services.

(6) Therapy services.

(7) Podiatry services.

(8) Chiropractic services.
(9) Durable medical equipment and supplies.
(10) Hospice services, subject to the conditions in 405 IAC 5-34-3.
(11) Diagnostic services, including genetic testing.

(Office of the Secretary of Family and Social Services; 405 IAC 5-5-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3308; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1904; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-5-2 Prior authorization requirements for out-of-state services

Authority: IC 12-8-6-5; 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 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, 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 has received services from the provider previously.
(3) Transportation to an appropriate Indiana facility would cause undue expense or hardship to the recipient 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)

405 IAC 5-5-3 Out-of-state suppliers of medical equipment
Authority: IC 12-8-6-5; 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 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)

Rule 6. Restricted Utilization

405 IAC 5-6-1 Restricted utilization; generally
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. Certain Medicaid recipients 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 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)*

405 IAC 5-6-2 Exceptions; emergency situations and referrals
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) A provider other than the one to whom the recipient is restricted may provide treatment to the recipient 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 is restricted may provide services to the recipient if the authorized provider has referred the recipient. *(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)*

Rule 7. Administrative Review and Appeals of Prior Authorization Determinations

405 IAC 5-7-1 Appeals of prior authorization determinations
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. (a) Medicaid recipients 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-*

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405 IAC 5-7-2 Provider requests for administrative review
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 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; 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)*

405 IAC 5-7-3 Conduct of administrative review
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 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 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 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)

Rule 8. Consultations and Second Opinions

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

Sec. 1. Medicaid reimbursement is available for consultations subject to the limitations contained in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-8-1; 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)*

405 IAC 5-8-2 "Consultation" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. As used in this rule, "consultation" means the rendering of a medical opinion by a physician for a specific recipient, 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)*

405 IAC 5-8-3 Restrictions

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

Sec. 3. (a) A consultation cannot be used for the evaluation of a nonphysician referred or self-referred recipient.

(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, 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 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)*

405 IAC 5-8-4 Confirmatory consultations

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

Sec. 4. (a) A confirmatory consultation is the rendering of a second or third medical opinion, completed by a physician for a specific recipient, 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.

(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)*

Rule 9. Evaluation and Management Services

405 IAC 5-9-1 Limitations

Authority: IC 12-8-6-5; 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. Medicaid reimbursement is available for office visits limited to a maximum of fifty (50) per rolling twelve (12) month period per recipient, 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)*

405 IAC 5-9-2 Restrictions

Authority: IC 12-8-6-5; 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, 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 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)*

405 IAC 5-9-3 Office visits exceeding established parameters

Authority: IC 12-8-6-5; 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 office visits exceeding the established parameters subject to prior authorization requirements at 405 IAC 5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 5-9-3; 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)*

Rule 10. Anesthesia Services

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)

405 IAC 5-10-2 "Anesthetist" defined

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. 2. As used in this rule, "anesthetist" means an anesthesiologist assistant (AA) or a certified registered nurse anesthetist (CRNA). *(Office of the Secretary of Family and Social Services; 405 IAC 5-10-2; 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)*

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, 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 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 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)*

405 IAC 5-10-4 Anesthesia administered during labor/delivery

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. 4. Anesthesia administered by the attending physician, during labor or delivery (spinals, epidurals, pudendal, caudal, paracervical blocks, etc.) are considered to be part of the delivery fee. If the anaesthesia is administered by another licensed anesthesia provider, that is, physician, anesthesiologist, or anesthetist, payment will be allowed for the procedures listed in this section under 405 IAC 1-11.5. *(Office of the Secretary of Family and Social Services, 405 IAC 5-10-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3312; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-10-5 Noncovered services

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. 5. The following are noncovered services under Medicaid when provided in conjunction with anesthesia services:
(1) Noninvasive electrocardiogram monitoring.
(2) Blood pressure monitoring.
(3) Monitoring of data scope.
(4) Intubation factor postoperative.
(Office of the Secretary of Family and Social Services; 405 IAC 5-10-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3312; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

Rule 11. Case Management Services for Pregnant Women

405 IAC 5-11-1 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-10-11-2; IC 12-13-7-3; IC 12-15; IC 25-22.5-1

Sec. 1. (a) As used in this rule, "care coordination services" means case management services. Providers of case management services, except for community health workers, will hereinafter be referred to as care coordinators.
(b) As used in this rule, "case management services for pregnant women" means an active, ongoing process of assisting the individual to identify, access, and utilize community resources and coordinating the services to meet individual needs. The term includes:
(1) locating service sources;
(2) making appointments for services;
(3) arranging transportation to services; and
(4) following up to verify appointments or reschedule appointments;
for Medicaid women whose pregnancies are at risk for low birth weight or poor pregnancy outcome. *(Office of the Secretary of Family and Social Services; 405 IAC 5-11-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3312; 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)*

405 IAC 5-11-2 Providers eligible for reimbursement; certification

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-10-11-2; IC 12-13-7-3; IC 12-15; IC 25-22.5-1

Sec. 2. (a) Medicaid reimbursement is available for care coordination services provided to eligible pregnant women by any of the following:
(1) A physician licensed by the state under IC 25-22.5-1.
(2) A registered nurse licensed by the state.
(3) A social worker with a baccalaureate or master's degree from a school accredited by the Council on Social Work Education or a social worker certified by the state.
(4) A dietitian registered with the Commission on Dietetic Registration of the American Dietetic Association.
(5) A community health worker working under the supervision of one (1) of the professionals as listed in subdivisions (1) through (4).
(b) All providers of care coordination services for pregnant women except for providers listed in subsection (a)(1) and (a)(5) must be certified by and have successfully completed care coordination training from a program approved by the office. Members of a medical doctor's or doctor of osteopathy's staff who perform care coordination services for their employers must be certified care coordinators. Community health workers must be certified by and have successfully completed community health worker's care coordination training from a program approved by the Indiana state department of health. *(Office of the Secretary of Family and Social Services; 405 IAC 5-11-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3312; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-11-3 Restrictions on services provided by community health workers

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-10-11-2; IC 12-13-7-3; IC 12-15; IC 25-22.5-1

Sec. 3. (a) A community health worker may perform all care coordination services except those set out as follows:

(1) A community health worker shall not perform the home encounter portion of the initial assessment described in section 4(1) of this rule.

(2) A community health worker shall not perform the postpartum or newborn assessment described in section 4(3) of this rule.

(b) Payment for services rendered by a community health worker will be made to the supervising professional as described in section 2(a)(1) through 2(a)(4) of this rule or the clinic providing all components of care coordination services.

(c) Care coordinators are reimbursed for performing the assessments described in section 4(1) through 4(3) of this rule. Assessments will be accomplished through encounters with a recipient, either by telephone or in person, in the recipient's home, or in the care coordinator's office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-11-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-11-4 Covered services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-10-11-2; IC 12-13-7-3; IC 12-15; IC 25-22.5-1

Sec. 4. The following are care coordination services that may be reimbursed by Medicaid:

(1) One (1) initial assessment that consists of the following:

(A) Risk assessment.
(B) Development of plan of care coordination.
(C) Referral and linkage to appropriate support services.
(D) Follow-up.
(E) Monitoring.

To be reimbursed for an initial assessment, at least two (2) encounters with the recipient must occur. One (1) of the encounters must be a visit in the recipient's home performed by the care coordinator; the other encounter may be performed by either the care coordinator or the community health worker. The initial assessment is limited to one (1) per pregnancy and must be completed during the prenatal period.

(2) Reassessments that consist of the following:

(A) Review and update of plan of care coordination.
(B) Referral and linkage to appropriate support services.
(C) Follow-up.
(D) Monitoring.

Reassessments are limited to one (1) per trimester following the trimester of initial assessment. To be reimbursed for each reassessment, the care coordinator or the community health worker must have at least two (2) encounters with the recipient, one (1) of which must occur in either the recipient's home or the care coordinator's office.

(3) One (1) postpartum assessment that consists of the following:

(A) Completion of postpartum and newborn assessment.
(B) Referral and linkage to appropriate support services.
(C) Completion of outcome report.

To be reimbursed for the postpartum assessment, the care coordinator must have one (1) encounter with the recipient during a home visit that takes place within sixty (60) days postpartum. Postpartum assessments are limited to one (1) per child born of the pregnancy following an initial assessment.

(4) Transportation expense for actual mileage at the rate set by the Indiana legislature for state employees under IC 4-10-11-2. Reimbursement for transportation expense from a community health worker's or care coordinator's place of doing business to a recipient's home and back is limited to the following:

(A) For an initial assessment, two (2) round trips.
(B) For each reassessment, two (2) round trips.
(C) For postpartum assessment, one (1) round trip.

(Office of the Secretary of Family and Social Services; 405 IAC 5-11-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-11-5 Initial assessments
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-10-11-2; IC 12-13-7-3; IC 12-15; IC 25-22.5-1

Sec. 5. All eligible pregnant women may receive initial assessment services; however, only those deemed at risk according to a prenatal risk assessment form approved by the office are eligible for additional services. When an initial assessment determines a pregnancy is not at risk, reassessment and postpartum assessment will not be covered services. However, services may be covered later in the pregnancy if risk factors from the prenatal risk assessment form, which were not evident or present during the initial assessment, are discovered. Documentation of risk status must be maintained by the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 5-11-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-11-6 Prior authorization
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-10-11-2; IC 12-13-7-3; IC 12-15; IC 25-22.5-1

Sec. 6. Care coordination services are exempt from prior authorization requirements. *(Office of the Secretary of Family and Social Services; 405 IAC 5-11-6; 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)*

405 IAC 5-11-7 Record keeping requirements
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-10-11-2; IC 12-13-7-3; IC 12-15; IC 25-22.5-1

Sec. 7. A care coordinator must maintain written documentation of all services provided under this rule. This written documentation must be maintained in the provider's office and shall be subject to postpayment review and audit by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-11-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3314; 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)*

Rule 12. Chiropractic Services

405 IAC 5-12-1 Reimbursement
Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-12-2 Office visits
Authority: IC 12-8-6-5; 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 per year which includes a

maximum reimbursement of no more than five (5) office visits per recipient 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. 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)

405 IAC 5-12-3 Chiropractic x-ray services

Authority: IC 12-8-6-5; 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 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 upon a recipient'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)

405 IAC 5-12-4 Laboratory services

Authority: IC 12-8-6-5; 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. 4. Laboratory services are reimbursable only when such services are necessitated by a condition-related diagnosis. *(Office of the Secretary of Family and Social Services; 405 IAC 5-12-4; 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)*

405 IAC 5-12-5 Muscle testing services

Authority: IC 12-8-6-5; 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. 5. Muscle testing services, either manual or electrical, are reimbursable only if prior authorization has been obtained. *(Office of the Secretary of Family and Social Services; 405 IAC 5-12-5; 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)*

405 IAC 5-12-6 Electromyography services (Repealed)

Sec. 6. *(Repealed by Office of the Secretary of Family and Social Services; filed May 1, 2003, 10:45 a.m.: 26 IR 2862)*

405 IAC 5-12-7 Durable medical equipment

Authority: IC 12-8-6-5; 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. 7. Medicaid reimbursement is not available for durable medical equipment (DME) provided by chiropractors. *(Office of the Secretary of Family and Social Services; 405 IAC 5-12-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 1, 2003, 10:45 a.m.: 26 IR 2862; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

Rule 13. Intermediate Care Facilities for the Mentally Retarded

405 IAC 5-13-1 Policy; definitions

Authority: IC 12-8-6-5; 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) when such services have been rendered to a Medicaid recipient 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" 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) that:

(1) provides ICF/MR 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 group home.

(c) As used in this section, "large private ICF/MR" means an institution certified as an intermediate care facility for the mentally retarded that:

(1) is not owned and/or operated 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" means a state owned or operated facility that provides ICF/MR 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)*

405 IAC 5-13-2 Reimbursement

Authority: IC 12-8-6-5; 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 in accordance with 405 IAC 1-4.

(b) Medicaid reimbursement is available for services provided by a large private or small ICF/MR in accordance with 405 IAC 1-12.

(c) The ICF/MR 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 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)*

405 IAC 5-13-3 Services included in the per diem rate for large private and small ICFs/MR

Authority: IC 12-8-6-5; 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 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 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 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 by the office and must be billed to the Medicaid program by the DME provider. Facilities shall not require Medicaid recipients 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 when the recipient no longer needs the equipment.

(8) Mental health services provided by the ICF/MR 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)

405 IAC 5-13-4 Services included in the per diem rate for large state ICFs/MR; exceptions

Authority: IC 12-8-6-5; 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 per diem rate for a large state ICF/MR shall include the following services:
(1) Room and board (room accommodations, dietary services, and laundry services).
(2) Medical services.
(3) Mental health services.
(4) Dental services.
(5) Therapy and habilitation services.
(6) Durable medical equipment (DME).
(7) Medical and nonmedical supplies.
(8) Pharmaceutical products.
(9) Transportation.
(10) Optometric services.

(b) The services set out in subsection (a) provided to a Medicaid resident residing in a large state ICF/MR 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 to a hospital for the purpose of performing dental services requires prior authorization by the office.

(3) 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 separately to Medicaid. Any other type of nonstandard DME requires prior authorization by the office and must be billed to Medicaid directly by the DME provider. Facilities cannot require recipients to purchase or rent such equipment with their personal funds. DME purchased by Medicaid becomes the property of the office. Such DME must be returned to the local county office of family and children when the recipient no longer requires the DME.

(4) Transportation services, except for emergency medical transportation services, are covered in the per diem rate. Transportation for emergency medical services must be billed to Medicaid directly by the transportation provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3316; filed Sep 27, 1999, 8:55 a.m.: 23 IR 311; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-13-5 Prior authorization for services rendered outside the large state ICF/MR

Authority: IC 12-8-6-5; 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. (a) Medical care rendered by practitioners outside the large state ICF/MR 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 5-13-5; 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)

405 IAC 5-13-6 Reserving beds

Authority: IC 12-8-6-5; 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 for Medicaid recipients, at one-half (½) 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 requires hospitalization longer than the fifteen (15) consecutive days, the recipient must be discharged from the facility. If the recipient is discharged from the ICF/MR following a hospitalization in excess of fifteen (15) consecutive days, the ICF/MR is still responsible for appropriate discharge planning if the ICF/MR does not intend to provide ongoing services following the hospitalization for those individuals who continue to require ICF/MR level of services. A physician's order for hospitalization must be maintained in the recipient's file at the facility.

(2) A leave of absence must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the recipient's habilitation plan. The total length of time allotted for therapeutic leaves in any calendar year shall be sixty (60) days per recipient residing in an ICF/MR. The leave days need not be consecutive. If the recipient is absent for more than sixty (60) days per year, no further Medicaid reimbursement shall be available for reserving a bed for that recipient in that year. A physician's order for the therapeutic leave must be maintained in the recipient'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 file at the ICF/MR 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)*

405 IAC 5-13-7 Admission and placement; large private and small ICFs/MR

Authority: IC 12-8-6-5; 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 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 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.

(b) The interdisciplinary professional team includes a physician, a certified social worker, and other professionals, one (1) of whom is a qualified mental retardation professional.

(c) A qualified mental retardation professional is a person as defined in 42 CFR 483.430.

(d) The following guidelines are applicable for admission and readmission of a recipient to a large private or small ICF/MR:

(1) The office must authorize Medicaid payment for each Medicaid recipient in the large private and small ICF/MR. 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 facilities requires diagnostic evaluation, including social and psychological components.

(3) BDDS or its designee must submit Form 450B, completed by the physician, for each Medicaid applicant or recipient 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 services.

(4) Both recipient 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 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, 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 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 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)

405 IAC 5-13-8 Admission to large state ICFs/MR

Authority: IC 12-8-6-5; 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 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 needs are met. The office must authorize the reimbursement of each Medicaid recipient 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)*

405 IAC 5-13-9 Inspection of care review team inspection (Repealed)

Sec. 9. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324)*

405 IAC 5-13-10 Transfer to another ICF/MR

Authority: IC 12-8-6-5; 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 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, 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 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)*

Rule 14. Dental Services

405 IAC 5-14-1 Policy

Authority: IC 12-8-6-5; 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 12-15-13-6

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 twenty-one (21) years of age and over, covered services routinely provided in a dental office will be limited to six hundred dollars ($600) per recipient, per twelve (12) month period. This limit precedes all other limits within this rule. The procedure codes that will be included within the limitation:

(1) will be listed and published in a provider bulletin; and

(2) may be updated by the office as needed.

A provider bulletin issued under this subsection shall be effective no earlier than permitted under IC 12-15-13-6.

(c) For those recipients 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)

405 IAC 5-14-2 Covered services

Authority: IC 12-8-6-5; 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 twenty (20) years of age and younger.

(5) Sealant for permanent molars and premolars for recipients twenty (20) years of age and younger.

(6) Amalgam.

(7) Unilateral and bilateral space maintainers for recipients 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 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 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 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)

405 IAC 5-14-3 Diagnostic services

Authority: IC 12-8-6-5; 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 every three (3) years.
(2) Bitewing radiographs are limited to one (1) set per recipient 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 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, per provider, with an annual limit of two (2) per recipient.
(6) A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient, 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)

405 IAC 5-14-4 Topical fluoride
Authority: IC 12-8-6-5; 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 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 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)*

405 IAC 5-14-5 Treatment of dental caries
Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-14-6 Prophylaxis
Authority: IC 12-8-6-5; 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 twelve (12) months of age up to their twenty-first birthday.
(2) One (1) unit every twelve (12) months for noninstitutionalized recipients twenty-one (21) years of age and older.
(3) Institutionalized recipients may receive up to one (1) unit every six (6) months.
(4) Prophylaxis is not covered for recipients 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)

405 IAC 5-14-7 Periodontal root planing and scaling
Authority: IC 12-8-6-5; 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 over three (3) years of age and under twenty-one (21) years of age, or for institutionalized recipients, is limited to four (4) units every two (2) years. For noninstitutionalized recipients 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)*

405 IAC 5-14-8 Extractions
Authority: IC 12-8-6-5; 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. 8. Medicaid reimbursement is available for extraction of teeth. Extraction of teeth must be medically necessary, and the diagnosis must support extraction. If multiple extractions are performed on the same date of service, the maximum allowable payment

for additional teeth will be reduced by ten percent (10%) of the maximum allowable for the first tooth. Payment for preoperative and postoperative care is included in the allowance for the operative procedure and may not be billed separately to Medicaid. Payment for placement of sutures or tissue trim, or both, in simple extractions is included in the reimbursement fee for the extractions and may not be billed separately to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-14-9 Space maintenance

Authority: IC 12-8-6-5; 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. 9. Medicaid reimbursement is available for space maintenance in children with deciduous molar teeth subject to the following restrictions:

(1) Space maintenance for children under three (3) years of age requires prior authorization by the office. Space maintenance for missing permanent teeth requires prior authorization by the office.

(2) Adjustment to space maintainers, bands, and all other appliances is included in the reimbursement for the service and may not be billed separately to Medicaid.

(3) All requests for prior authorization will be reviewed on a case-by-case basis by the contractor.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-14-10 Pulpcap (Repealed)

Sec. 10. *(Repealed by Office of the Secretary of Family and Social Services; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2865)*

405 IAC 5-14-11 Analgesia

Authority: IC 12-8-6-5; 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. 11. Nitrous oxide analgesia is covered only for those twenty (20) years of age and younger. Preanesthetic medication is a covered service for all ages. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-11; 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)*

405 IAC 5-14-12 Infection control

Authority: IC 12-8-6-5; 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. 12. Infection control is not a covered service. All routine supplies and services should be included in the reimbursement amount for the procedure. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-12; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-14-13 Emergency treatment of dental pain

Authority: IC 12-8-6-5; 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. 13. Palliative treatment of facial pain, such as abscess, incision, and drainage, is limited to emergency treatment only. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-14-14 Office visits

Authority: IC 12-8-6-5; 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. 14. Payment for office visits is not covered. Reimbursement is available only for covered services actually performed. Covered services provided outside the 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 5-14-14; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-14-15 General anesthesia and intravenous sedation

Authority: IC 12-8-6-5; 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 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 cannot receive necessary dental services unless general anesthesia is administered. For example, a recipient 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)*

405 IAC 5-14-16 Periodontics; surgical

Authority: IC 12-8-6-5; 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. 16. Periodontic surgery is a covered service only for cases of drug-induced periodontal hyperplasia. Documentation in the patient's record must substantiate that the service was provided for drug-induced periodontal hyperplasia. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-16; 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)*

405 IAC 5-14-17 Oral surgery

Authority: IC 12-8-6-5; 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. 17. No oral surgical procedures shall be reimbursed other than those listed in this rule and as defined by provider bulletin. Placement of sutures or tissue trim, or both, in a simple extraction does not constitute a surgical extraction. Multiple simple extractions with placement of sutures or tissue trim, or both, performed in either office or hospital shall not be reimbursed as surgical extractions. Payment of preoperative and postoperative care is included in the reimbursement for the operative procedure and may not be billed separately to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-17; 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)*

405 IAC 5-14-18 Hospital admissions for covered dental services or procedures

Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-14-19 Prior authorization for early and periodic screening, diagnostic, and treatment covered services

Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-14-20 Dental services provided in a state owned ICF/MR

Authority: IC 12-8-6-5; 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 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)

405 IAC 5-14-21 Maxillofacial surgery

Authority: IC 12-8-6-5; 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)*

Rule 15. Early and Periodic Screening, Diagnostic, and Treatment Services

405 IAC 5-15-1 Policy

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

Sec. 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 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)*

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

Sec. 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 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)*

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

Sec. 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 chooses to participate in the EPSDT program, or until the recipient 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)

405 IAC 5-15-4 Treatment
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. Any treatment found 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 subject to prior authorization requirements of 405 IAC 5-4 if it is 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)*

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

Sec. 5. Prior authorization is not required for screening services. Treatment services are subject to the same prior authorization

requirements for the services as set out in this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-15-5; 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)*

405 IAC 5-15-6 Recipient and provider participation

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

Sec. 6. (a) Any Medicaid recipient under twenty-one (21) years of age may participate in the EPSDT program. Each recipient will be informed about the program by the office or its designee in accordance with federal regulations. Participation in EPSDT by Medicaid recipients 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)*

405 IAC 5-15-7 Screening referrals

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

Sec. 7. Providers of services who perform screening or treatment services as a result of an EPSDT screening referral shall be subject to the same limitations for such services as set out in this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-15-7; 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)*

405 IAC 5-15-8 EPSDT periodicity and screening schedule

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

Sec. 8.

Every child and family is unique, therefore this Periodicity and Screening Schedule has been designed as a preventive health care plan for children with the absence of any significant health problems who are growing and developing in satisfactory fashion. This Schedule may need to be adjusted to meet the health care needs of specific patients.

This Periodicity Schedule reflects recommendations of the American Academy of Pediatrics along with those of the Hoosier Healthwise Clinical Advisory Committee and is meant to be a guide for Indiana Medicaid Providers participating in the EPSDT - HealthWatch Program. This program emphasizes the importance of early and periodic screening for specific conditions, as outlined below, and the need for continued diagnosis and treatment of conditions and symptoms identified by practicing professionals through the use of this Schedule.

	INFANCY[3]								EARLY CHILDHOOD[3]					MIDDLE CHILDHOOD[3]				ADOLESCENCE[3]				
AGE[4]	NEWBORN[1]	2-4d[2]	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y
HISTORY:INITIAL/INTERVAL	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																						
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●	●											
Blood Pressure												●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																						
Vision[5]	S	S	S	S	S	S	S	S	S	S	S	O[5]	O	O	S	S	O	O	S	S	O	S
Hearing[5]	S/R	S	S	S	S	S	S	◄	─	─	─	─	O	O	S	S	O[6]	O[6]	S	S	O[6]	S
DEVELOPMENTAL/ BEHAVIOR ASSESSMENT	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[8]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES - GENERAL																						
Immunization[9]	● ─	─ ►	●	●	●			◄	●	►			◄	●	►			●	►			
Lead Screening[10]							● ─	►			●	R	R	R	R	R	R	R	R	R	R	R
Hematocrit or Hemoglobin			◄	─	─	─	●				●			●				◄	11	─	─	►
Urinalysis														●				◄	12	─	─	►
PROCEDURES - PATIENTS AT RISK																						
Tuberculin Test[13]								R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Sickle Cell Test[14]	●																					
Drug/HIV Testing[15]	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
STD Screening[16]																		R	R	R	R	R
Pelvic Exam																		R	R	◄	17 ►	R
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Injury Prevention	●			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Dental Referral								◄	─	─	●	●	●	●	●	●	●	●	●	●	●	●
Dental Observation[18]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Newborn Infant Screen[19]	◄ ►																					

[1]Breastfeeding encouraged and supported.

[2]For newborns discharged in less than 48 hours after delivery.

[3]Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

[4]If a child comes under care for the first time at any point on this schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

[5]If the patient is uncooperative, rescreen within six months. If objective vision methods indicate, refer to optometrist/ophthalmologist.

[6]Not to be duplicated if done in school system.

[7]By history and appropriate physical examination: if suspicious, by specific objective developmental testing.

[8]At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.

[9]According to the schedule currently recommended by the American Academy of Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.

[10]Blood lead screening, as recommended by the AAP at indicated intervals and for patients at risk.

[11]All menstruating adolescents should be screened.

[12]A dipstick urinalysis for leukocytes for male and female adolescents.

[13]Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing. The frequency of skin testing should be according to the degree of risk.

[14]Should be performed one time only, when clinically indicated, or if not done in the newborn screen.

[15]Should be done on newborns and annually for those at risk, with patient/parent consent.

[16]All sexually active patients should be screened for sexually transmitted diseases (STDs).

[17]All sexually active females should have a pelvic examination. A pelvic exam and routine pap smear should be offered between the ages of 18 and 21 as part of an active preventive health plan.

[18]Dental referral may include flouride treatments.

[19]Must be done 48 hours after birth.

Please consult the EPSDT - HealthWatch Program Provider Manual for immunization schedules and risk factor definitions.

Key: ● = to be performed R = to be performed on patients at risk S = subjective, by history O = objective, by a standard testing method
◄ ► = range during which a service may be provided, with the dot or number indicating the preferred age

(Office of the Secretary of Family and Social Services; 405 IAC 5-15-8; 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)

Rule 16. Home Health Agency and Clinic Services

405 IAC 5-16-1 Providers eligible for reimbursement

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

Sec. 1. Services provided to a recipient 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)*

405 IAC 5-16-2 Home health agency services

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

Sec. 2. Medicaid reimbursement is available to home health agencies for:
(1) skilled nursing services provided by a registered nurse or licensed practical nurse;
(2) home health aide services;
(3) physical, occupational, and respiratory therapy services;
(4) speech pathology services; and
(5) renal dialysis;
when such services are provided within the limitations listed in sections 3 and 3.1 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-16-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3325; filed Aug 27, 1999, 10:15 a.m.: 23 IR 16; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-16-3 Prior authorization for home health agency services; generally

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

Sec. 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:

(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 on self-care techniques in the home and (or) need for instructing the caregiver on caring for the recipient in the home.

(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, 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 *[sic., limit]* the ability of the caregiver to provide care to the recipient.

(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 medical needs.

(M) Whether the recipient 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, 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.

(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)

405 IAC 5-16-3.1 Home health agency services; limitations

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

Sec. 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.
(7) Provided only to recipients who are medically confined to the home as certified by the attending or primary physician.

(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.
(6) Provided only to recipients who are medically confined to the home as certified by the attending or primary physician.

(c) Nursing services, which do not meet the definition of emergency services, are covered without prior authorization when provided to a recipient 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. *(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)*

405 IAC 5-16-4 Rehabilitation center services; limitations

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

Sec. 4. Medicaid reimbursement is available for rehabilitation center services provided by appropriately licensed, certified, or registered staff members subject to the following limitations:

(1) All rehabilitation center services require prior authorization by the department, except those services ordered in writing by a physician prior to the patient's discharge from a hospital. Any combination of therapy services ordered in writing may not exceed thirty (30) hours, sessions, or visits in thirty (30) calendar days unless prior authorization is obtained from the department.
(2) All services must be ordered in writing by a physician.
(3) All services must be provided in accordance with a written plan of care developed cooperatively between the therapist or psychologist and the attending physician.
(4) All services must be medically necessary. Educational services, including, but not limited to, the remediation of learning disabilities are not covered by Medicaid.
(5) All therapies provided in a rehabilitation center must be provided in accordance with 405 IAC 5-22.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-4; 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)

405 IAC 5-16-5 Rural health clinics and federally qualified health clinics; reimbursement
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 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. 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)*

405 IAC 5-16-6 Free-standing clinics and surgical centers; limitations
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. Medicaid reimbursement is available to free-standing clinics and surgical centers for services provided to recipients 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)

Rule 17. Hospital Services

405 IAC 5-17-1 Reimbursement; limitations
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 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 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 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)*

405 IAC 5-17-2 Prior authorization; generally

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

Sec. 2. (a) 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.

(b) 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, but will be subject to retrospective review for medical necessity.

(c) 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.

(d) Days that are not prior authorized under the level of care methodology as required by this rule will not be covered by Medicaid.

(e) Prior authorization is 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)*

405 IAC 5-17-3 Emergency; weekend inpatient admissions

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

Sec. 3. Emergency inpatient admissions for diagnoses reimbursed under the level of care payment methodology and emergency substance abuse inpatient admissions must be reported to the office within forty-eight (48) hours of admission, not including Saturdays, Sundays, or legal holidays, in order to receive Medicaid reimbursement. At that time, the same standards for prior authorization will be applied as would have been applied if the authorization had been requested before the admission. *(Office of the Secretary of Family and Social Services; 405 IAC 5-17-3; 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)*

405 IAC 5-17-4 Physical rehabilitation services

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

Sec. 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)

405 IAC 5-17-5 Inpatient detoxification, rehabilitation, and aftercare for chemical dependency

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

Sec. 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)

Rule 18. Laboratory Services

405 IAC 5-18-1 Clinical diagnostic laboratory services; reimbursement

Authority: IC 12-8-6-5; 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. Most clinical diagnostic laboratory procedures, performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients, will be reimbursed on the basis of fee schedules established by Medicare. For purposes of this fee schedule, clinical diagnostic services include all laboratory tests. Laboratory procedures are subject to the Clinical Laboratories Improvement Act (CLIA) rules and regulations. *(Office of the Secretary of Family and Social Services; 405 IAC 5-18-1; 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)*

405 IAC 5-18-2 Reimbursement restrictions

Authority: IC 12-8-6-5; 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) A fee will be reimbursed by Medicaid for separate charges made by physicians, independent laboratories, or hospital laboratories for the drawing of or collection of specimens. These services are covered only in circumstances when a blood sample is drawn through venipuncture or where a urine sample is collected by catheterization.

(b) Billings on the claim form for specimen collection fees must be itemized. Only one (1) charge per day for each patient shall be allowed for venipuncture. A charge for catheterization will be allowed for each patient encounter, that is, there is no per day or per claim limitation.

(c) Handling or conveyance of a specimen will be reimbursed by Medicaid if these services are billed by a physician,

chiropractor, or podiatrist. *(Office of the Secretary of Family and Social Services; 405 IAC 5-18-2; 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)*

405 IAC 5-18-3 Inpatient and outpatient laboratory facilities; limitations
Authority: IC 12-8-6-5; 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. (a) To be eligible for reimbursement, a laboratory service must be ordered in writing by a physician or other practitioner authorized to do so under state law.

(b) Laboratories performing the services must bill Medicaid directly unless otherwise approved by the Health Care Financing Administration. *(Office of the Secretary of Family and Social Services; 405 IAC 5-18-3; 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)*

405 IAC 5-18-4 Nonanatomical laboratory procedures
Authority: IC 12-8-6-5; 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 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;

(3) result in a written narrative report included in the patient'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)

Rule 19. Medical Supplies and Equipment

405 IAC 5-19-1 Medical supplies
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
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 items:

(1) Antiseptics and solutions.

(2) Bandages and dressing supplies.

(3) Gauze pads.

(4) Catheters.

(5) Incontinence supplies.

(6) Irrigation supplies.

(7) Diabetic supplies.

(8) Ostomy supplies.

(9) Respiratory and tracheotomy supplies.

(c) Covered medical supplies do not include the following items:

(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 in accordance with the instructions set forth in the Indiana health coverage programs manual or update bulletins.

(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 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 is a Medicare beneficiary 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 to be effective on the effective date of this rule is the base statewide fee schedule amount equal to the lower of the Medicaid fee schedule amount in effect during state fiscal year (SFY) 2001 or the amount determined as follows:

(1) 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 (2).

(2) The Indiana Medicare fee schedule amount adjusted by a multiplier of no less than eight-tenths (.8), if available. If this amount is not available, then subdivision (3).

(3) The weighted median of providers' usual and customary charges adjusted by a multiplier of no less than eight-tenths (.8), if available. If this amount is not available, then subdivision (4).

(4) The Medicaid fee schedule amount in effect during SFY 2001, if available. If this amount is not available, then subdivision (5).

(5) The average Indiana Medicaid payment amount per item during SFY 2001.

(l) The office may review the statewide fee schedule and adjust it as necessary using the:

(1) Medicare fee schedule; and

(2) the providers':

(A) usual and customary charges; and

(B) acquisition cost information;

subject to subsection (k)(1) through (k)(5). Any adjustments shall be made effective no earlier than permitted under IC 12-15-13-6.

(m) Providers must bill for medical supplies using the health care common procedure coding system in accordance with the instructions set forth in the Indiana health coverage programs manual or update bulletins.

(n) 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)

405 IAC 5-19-2 "Durable medical equipment" or "DME" defined

Authority: IC 12-8-6-5; 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 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)

405 IAC 5-19-3 Reimbursement parameters for durable medical equipment

Authority: IC 12-8-6-5; 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. (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 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 to purchase or rent such equipment with their personal funds.

(c) Reimbursement of DME is based upon Medicare's fee schedule for fiscal year 1993 and classes of DME. The established Medicaid rates will be reviewed annually and adjusted as necessary. A separate fee schedule will be established for each of the following six (6) classes:

(1) Capped rental items.
(2) Inexpensive and other routinely purchased DME.
(3) Items requiring frequent and substantial servicing.
(4) Customized items.
(5) Prosthetic and orthotic devices.
(6) Oxygen and oxygen equipment.

(d) DME reimbursed at less than one hundred fifty dollars ($150) or other amount as defined by the office will not be subject to the capped rental payment, but rather be reimbursed on a rental or lump sum purchase with prior authorization. The total payment for the rental period may not exceed the purchase price.

(e) 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.

(f) 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)*

405 IAC 5-19-4 Repair of purchased durable medical equipment
Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-19-5 Reimbursement for replacement durable medical equipment
Authority: IC 12-8-6-5; 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 unless there is a change in the recipient'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)*

405 IAC 5-19-6 Durable medical equipment subject to prior authorization
Authority: IC 12-8-6-5; 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 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 in a home setting. The recipient'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)*

405 IAC 5-19-7 Prior authorization criteria
Authority: IC 12-8-6-5; 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, 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 based on the least expensive option available to meet the recipient'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)

405 IAC 5-19-8 Ownership of durable medical equipment

Authority: IC 12-8-6-5; 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)*

405 IAC 5-19-9 Wheelchairs and similar motorized vehicles

Authority: IC 12-8-6-5; 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 is enrolled in a school, sheltered workshop, or work setting, or if the recipient is left alone for significant periods of time. It must be documented that the recipient can safely operate the vehicle and that the recipient 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)*

405 IAC 5-19-10 Braces and orthopedic shoes

Authority: IC 12-8-6-5; 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. Medicaid reimbursement is available for the following:

(1) Braces for the leg, arm, back, and neck.

(2) Orthopedic shoes and corrective shoe features.

(3) Corrective features built into shoes, such as heels, lifts, and wedges.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-10; 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; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2134; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-19-11 Prosthetic devices

Authority: IC 12-8-6-5; 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. 11. Medicaid reimbursement is available for prosthetic devices under the following conditions:

(1) All prosthetic devices must be ordered in writing by a physician, optometrist, or dentist.

(2) Prior authorization by the office is required for all basic prosthetic components and repairs. Once the basic prosthesis is approved, all customizing features will be exempt from prior authorization.

(3) Prosthetic devices dispensed for purely cosmetic reasons, for example, hairpieces or makeup, are not covered by Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-11; 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)

405 IAC 5-19-12 Home hemodialysis equipment

Authority: IC 12-8-6-5; 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 relocation is limited to moves made necessary by circumstances beyond the recipient'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)*

405 IAC 5-19-13 Hearing aids; purchase

Authority: IC 12-8-6-5; 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. 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 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. All hearing aids purchased by the office, which are no longer needed by a recipient, must be returned to the county office of family and children.

(4) Hearing aids are not covered for recipients 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 can be documented.

(6) Medicaid does not reimburse for canal hearing aids.

(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)

405 IAC 5-19-14 Hearing aids; maintenance and repair

Authority: IC 12-8-6-5; 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. 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 under eighteen (18) 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 Medicaid program.

(5) No payment shall be made for repair or replacement of hearing aids necessitated by recipient 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)

405 IAC 5-19-15 Hearing aids; replacement

Authority: IC 12-8-6-5; 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. 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 document a change in the recipient's hearing status and must 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 under eighteen (18) 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)

405 IAC 5-19-16 Augmentative communication devices

Authority: IC 12-8-6-5; 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 has demonstrated sufficient mental and physical capabilities to benefit from the use of the system.

(2) Documentation must be presented that substantiates the recipient, 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 medical condition is such that at least two (2) years of use of the device by the recipient can reasonably be expected.

(4) Documentation must be presented that:

(A) identifies all communication devices that would meet the recipient's communication needs, taking into account the physical and cognitive strengths and weaknesses of the recipient and the recipient'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 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)

405 IAC 5-19-17 Pneumatic artificial voicing systems

Authority: IC 12-8-6-5; 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 has demonstrated sufficient mental and physical capabilities to benefit from the use of the system.

(2) Documentation must be presented that substantiates the recipient 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)*

405 IAC 5-19-18 Noncovered durable medical equipment

Authority: IC 12-8-6-5; 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 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 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)

Rule 20. Mental Health Services

405 IAC 5-20-1 Reimbursement limitations

Authority: IC 12-8-6-5; 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 under sixty-five (65) years of age unless the recipient 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)*

405 IAC 5-20-2 Reserving beds in psychiatric hospitals and psychiatric residential treatment facilities

Authority: IC 12-8-6-5; 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 at one-half (½) 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 requires hospitalization longer than the fifteen (15) consecutive days, the recipient must be discharged from the facility.

(3) A physician's order for the hospitalization must be maintained in the recipient's file at the facility.

(b) Medicaid reimbursement is available for reserving beds in a psychiatric residential treatment facility for hospitalization of Medicaid recipients under twenty-one (21) years of age at one-half (½) 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 requires hospitalization longer than the four (4) consecutive days, the recipient must be discharged from the psychiatric residential treatment facility.

(3) A physician's order for the hospitalization must be maintained in the recipient'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 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 at one-half (½) 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 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. If the recipient 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 in that year.

(3) A physician's order for therapeutic leave must be maintained in the recipient'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 under twenty-one (21) years of age at one-half (½) 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 habilitation plan.

(2) A physician's order for therapeutic leave must be maintained in the recipient'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. If the recipient 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 in that year.

(4) In no instance will Medicaid reimburse a psychiatric residential treatment facility for reserving beds for Medicaid recipients 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)

405 IAC 5-20-3 Requirements for psychiatric hospitals

Authority: IC 12-8-6-5; 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 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. 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)

405 IAC 5-20-3.1 Psychiatric residential treatment facilities; requirements

Authority: IC 12-8-6-5; 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. 3.1. Psychiatric residential treatment facilities must meet the following conditions in order to be reimbursed for inpatient services:

(1) The facility must be licensed as a private secure care institution under 470 IAC 3-13.

(2) The facility must be accredited by one (1) of the following:

(A) The Joint Commission on Accreditation of Healthcare Organizations.

(B) The American Osteopathic Association.

(C) The Council on Accreditation of Services for Families and Children.

(3) The facility must comply with all requirements in 42 CFR 483, Subpart G governing the use of restraint and seclusion.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-3.1; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2477; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-20-4 Individually developed plan of care

Authority: IC 12-8-6-5; 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 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 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 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 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 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 community to ensure continuity of care when returned to the patient'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 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 overall adjustment as an inpatient. The quarterly plan of care must be in writing and made a part of the patient's record.

(2) The individual plan of care for a recipient 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 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)

405 IAC 5-20-5 Certification of need for admission

Authority: IC 12-8-6-5; 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 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 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 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 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 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)

405 IAC 5-20-6 Emergency admissions

Authority: IC 12-8-6-5; 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 for emergency admissions only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one (1) of the following:

(1) Danger to the individual.

(2) Danger to others.

(3) Death of the individual.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-6; 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)

405 IAC 5-20-7 Unnecessary services

Authority: IC 12-8-6-5; 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. Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization or stay in a psychiatric residential treatment facility is found not to have been medically necessary. Telephone precertifications of medical necessity will provide a basis for Medicaid reimbursement only if adequately supported by the written certification of need submitted in accordance with section 5 of this rule. If the required written documentation is not submitted within the specified time frame, Medicaid reimbursement will be denied. *(Office of the Secretary of Family and Social Services; 405 IAC 5-20-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2478; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-20-8 Outpatient mental health services

Authority: IC 12-8-6-5; 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 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 such 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.
(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 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 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 for evaluation and group, family, and individual psychotherapy when provided by a psychologist endorsed as an HSPP.

(5) Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when provided by a physician or an HSPP.

(6) Prior authorization is required for mental health services provided in an outpatient or office setting that exceed twenty (20) units per recipient, 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 (5).

(7) The following are services that are not reimbursable by the Medicaid program:

(A) Day care.
(B) Hypnosis.
(C) Biofeedback.
(D) Missed appointments.
(E) Partial hospitalization, except as set out in 405 IAC 5-21.

(8) 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.

(9) 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.

(10) For psychiatric diagnostic interview examinations, Medicaid reimbursement is available for one (1) unit per recipient, 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, per provider, may be reimbursed without prior authorization, when a recipient 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)

Rule 21. Community Mental Health Rehabilitation Services

405 IAC 5-21-1 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15; IC 12-29; IC 25-23-1-1

Sec. 1. (a) As used in this rule, "community mental health rehabilitation services" means the following:

(1) Outpatient mental health services.

(2) Partial hospitalization services.

(3) Case management services for persons who are seriously mentally ill or seriously emotionally disturbed.

(4) Assertive community treatment (ACT) intensive case management services are services provided by a multidisciplinary team that has the responsibility for the direct provision of community-based psychiatric treatment, assertive outreach, rehabilitation, and support services to an adult Medicaid population with serious mental illness that also have co-occurring problems or multiple hospitalizations. The team must be regularly certified or provisionally certified as defined in 440 IAC 5.2-2.

(b) As used in this rule, "community mental health services" refers to community mental health rehabilitation services.

(c) As used in this rule, "qualified mental health professional" means any of the following persons:

(1) A psychiatrist.

(2) A physician.

(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).

(4) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of any of the persons listed in subdivision (1), (2), or (3), 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 social work from a university accredited by the Council on Social Work Education.

(C) In psychology from an accredited university.

(D) In mental health counseling from an accredited university.

(E) In pastoral counseling from an accredited university.

(F) In rehabilitation counseling from an accredited university.

(G) In marital and family therapy from an accredited university.

(5) A licensed independent practice school psychologist under the supervision of any of the persons listed in subdivision (1), (2), or (3).

(6) An individual who has documented education, training, or experience, comparable or equivalent to those listed in this subsection, as approved by the supervising physician or HSPP, under the supervision of any of the persons listed in subdivision (1), (2), or (3).

(7) An advanced practice nurse under IC 25-23-1-1(b)(3) who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center under the supervision of any of the persons listed in subdivision (1), (2), or (3).

(d) As used in this rule, "situational trauma" means an extremely upsetting emotional experience that aggravates or contributes to a mental illness.

(e) As used in this rule, "consumer" means an individual who is receiving assessment or mental health services from an assertive community treatment team and is a recipient of Medicaid.

(f) As used in this rule, "certification" is an ACT team that is regularly certified or provisionally certified by department of

mental health and addiction (DMHA) and does not include conditional certification as defined in 440 IAC 5.2-2-10. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3336; filed Sep 27,1999, 8:55 a.m.: 23 IR 316; filed Jun 9, 2000, 9:55 a.m.: 23 IR 2708; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 26, 2004, 3:45 p.m.: 27 IR 2245; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-21-2 Reimbursement

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15; IC 12-29

Sec. 2. Medicaid will reimburse for community mental health services for persons with mental illness when those services are provided:

(1) through a mental health center that is an enrolled Medicaid provider and meets applicable federal, state, and local laws concerning the operation of community mental health centers, including, but not limited to:
  (A) licensure;
  (B) certification;
  (C) organization;
  (D) staffing;
  (E) service provision;
  (F) maintenance of health records;
  (G) quality assurance;
  (H) program evaluation; and
  (I) requirements for approval of the division of mental health under IC 12-29 and in accordance with 440 IAC 4; 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 qualified mental health professional.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3336; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-21-3 Outpatient services

Authority: IC 12-8-6-5; 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. (a) The services reimbursable as outpatient mental health services are clinical mental health services that are provided to individuals, families, or groups of persons who are living in the community and who need aid on an intermittent basis for emotional disturbances or mental illness, including, but not limited to, the following:

(1) Diagnostic assessment.
(2) Prehospitalization screening.
(3) Individual counseling or psychotherapy.
(4) Conjoint counseling or psychotherapy.
(5) Family counseling or psychotherapy.
(6) Group counseling or psychotherapy.
(7) Crisis intervention.
(8) Medication or somatic treatment.
(9) Training in activities of daily living.

(b) Outpatient mental health services may include the following:

(1) Clinical attention in the recipient's home, workplace, mental health facility, emergency room, or wherever needed.
(2) The emergency provision of chemotherapy, first aid, or other medical care.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3337; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-21-4 Partial hospitalization services
Authority: IC 12-8-6-5; 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. The services reimbursable as partial hospitalization services consist of group activity programs provided two (2) or more hours per day for individuals who need less than full-time hospitalization but more extensive and structured treatment than on an intermittent, hourly basis. These services are provided in the following manner:
(1) On part days, evenings, or weekends.
(2) By a clinical team.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3337; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-21-5 Case management services
Authority: IC 12-8-6-5; 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. The services reimbursable as case management services are goal oriented activities that assist individuals by locating, coordinating, and monitoring necessary care and services appropriate and accessible to the recipient. Requirements for case management services shall be as follows:
(1) Components of case management services are as follows:
(A) Identification and outreach.
(B) Individual assessment.
(C) Service planning.
(D) Implementation.
(E) Monitoring of service delivery and utilization.
(F) Reassessment.
(2) Case management services will be provided to adults who are eighteen (18) years of age and older, who are determined to be seriously mentally ill under all of the following criteria:
(A) The individual has a mental illness diagnosis under Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, Washington, D.C., 1994 (hereinafter, DSM-IV); any secondary material incorporated by DSM-IV is not incorporated herein.
(B) The individual experiences significant functional impairments in two (2) of the following areas:
(i) Activities of daily living.
(ii) Interpersonal functioning.
(iii) Concentration, persistence, and pace.
(iv) Adaptation to change.
(C) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the durational requirement of this clause.
(3) Case management services will be provided to a child who is seventeen (17) years of age or younger who is determined to be seriously emotionally handicapped under all of the following criteria:
(A) The child has a mental illness diagnosis under DSM-IV.
(B) The child experiences significant functional impairments in at least one (1) of the following areas:
(i) Activities of daily living.
(ii) Interpersonal functioning.
(iii) Concentration, persistence, and pace.
(iv) Adaptation to change.
(C) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, children who have experienced a situational trauma, and who are receiving services in two (2) or more community agencies, do not have to meet the durational requirement of this clause.
(4) Case management services will be provided to adults who are eighteen (18) years of age and older, who are determined to have a substance-related disorder under all of the following criteria:

(A) The individual has a substance-related disorder in DSM-IV.
(B) The individual experiences significant functional impairments in two (2) of the following areas:
(i) Activities of daily living.
(ii) Interpersonal functioning.
(iii) Ability to live without recurrent use of chemicals.
(iv) Psychological functioning.
(C) The duration of the addiction has been in excess of twelve (12) months. However, individuals who have experienced amnesiac episodes (blackouts), convulsions, or other serious medical consequences of withdrawal from a chemical abuse, or who display significant dangerousness as a result of chemical use, do not have to meet the durational requirement of this clause.

(5) Case management services will be provided to children who are seventeen (17) years of age and younger, who are determined to have a substance-related disorder under all of the following criteria:
(A) The child has a substance-related disorder in DSM-IV.
(B) The child experiences significant functional impairments in one (1) of the following areas:
(i) Activities of daily living.
(ii) Interpersonal functioning.
(iii) Ability to live without recurrent use of chemicals.
(iv) Psychological functioning.
(C) The duration of the addiction has been in excess of twelve (12) months. However, children who have experienced amnesiac episodes (blackouts), convulsions, or other serious medical consequences of withdrawal from a chemical abuse, or who display significant dangerousness as a result of chemical use, do not have to meet the durational requirement of this clause.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3337; filed Sep 27, 1999, 8:55 a.m.: 23 IR 316; 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)

405 IAC 5-21-6 Diagnosis; plan of treatment
Authority: IC 12-8-6-5; 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. The supervising physician or health service provider in psychology (HSPP) bears the ultimate responsibility for certifying the diagnosis and plan of treatment for community mental health rehabilitation services. The supervising physician or HSPP is responsible for seeing the patient during the intake process or reviewing information submitted by the qualified mental health professionals and approving the initial treatment plan within seven (7) days. The supervising physician or HSPP must see the patient or review the treatment plan submitted by the qualified mental health professional at intervals not to exceed ninety (90) days. These reviews must be documented in writing. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; filed Jun 9, 2000, 9:55 a.m.: 23 IR 2709; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-21-7 Prior authorization (Repealed)

Sec. 7. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 18, 2009, 11:32 a.m.: 20090916-IR-405080192FRA)*

405 IAC 5-21-8 Assertive community treatment intensive case management
Authority: IC 12-8-6-5; 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. (a) The services reimbursable as assertive community treatment (ACT) intensive case management services are goal oriented and intended to maintain an individual outside of the hospital. Services may be provided only to Medicaid recipients with serious mental illness who also have co-occurring problems or multiple hospitalizations.

(b) Medicaid recipients receiving assertive community treatment intensive case management services as consumers must meet the following criteria:

(1) The ACT admission and discharge criteria in accordance with 440 IAC 5.2-2-4.

(2) Recipient's level of functioning must be low or moderate as per the most recently released DMHA mental illness risk-adjusted groups defined in the risk-level flow chart for mental illness developed by DMHA as contained in provider bulletins and updates.

(c) Provider qualifications for assertive community treatment intensive case management services shall be as follows:

(1) ACT teams must be certified in accordance with 440 IAC 5.2-2. ACT teams on conditional certification status as defined by 440 IAC 5.2-2-10 do not meet Medicaid requirements for reimbursement.

(2) Each regularly certified ACT team must be composed of the staff requirements in accordance with 440 IAC 5.2-2-3(a).

(3) Each regularly certified team shall meet regular operational standards in accordance with 440 IAC 5.2-2-3(b) and as follows:

(A) Support and rehabilitation services as defined in 440 IAC 5.2-2-5, including the majority if not all behavioral and mental health direct clinical and rehabilitative services are also provided by this same team.

(B) The team shall monitor hospitalization, housing, and employment outcomes for all consumers in accordance with 440 IAC 5.2-2-6.

(4) Each provisional certified ACT team must comply with staffing and operational requirements in accordance with 440 IAC 5.2-2-8.

(d) Prior authorization is required for assertive community treatment intensive case management services. Requests for prior authorization must contain the information specified in 405 IAC 5-3 and the following:

(1) Medicaid provider identification number of the certified assertive community treatment team's community mental health center.

(2) Patient's Hoosier Assurance Plan Instrument-Adult level of functioning factor scores at the patient's most recent assessment and the date of that assessment.

(3) Clinical summary including:

(A) Documentation of any institutionalizations and hospital visits related to the patient's condition in the last two (2) years and any other documentation supporting the patient's severe limitations with activities of daily living.

(B) A current plan of treatment and progress notes documenting the necessity, effectiveness, and goals of treatment.

(C) Documentation detailing how the patient has met the community mental health center's requirements for participation as defined in 440 IAC 5.2-2-4 in the community mental health center's assertive community treatment program.

(4) Signature of assertive community treatment team's psychiatrist.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21-8; filed Feb 26, 2004, 3:45 p.m.: 27 IR 2245; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

Rule 22. Nursing and Therapy Services

405 IAC 5-22-1 Definitions

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

Sec. 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) "Chronic medical condition or rehabilitation condition" means any injury or insult with onset and sequelae extending past one (1) year.

(4) "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.

(5) "Maintenance therapy" means therapy addressing chronic medical conditions where further progress can no longer be expected or where progress is minimal in relation to the time needed in therapy to achieve that progress. The recipient's inability to maintain previous therapy gains, despite an unchanging medical diagnosis or condition, would indicate that further therapy intervention would be of limited value to the recipient.

(6) "Medically necessary therapy" means therapy for the restoration of an impaired level of function caused by an acute change in medical condition.

(7) "Outpatient therapy services" means services provided to a recipient outside the recipient's primary place of residence.

(8) "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)

405 IAC 5-22-2 Nursing services; prior authorization requirements

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

Sec. 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. 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. *(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)*

405 IAC 5-22-3 Certified nurse midwife services

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

Sec. 3. Medicaid reimbursement is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform, including well-woman gynecological healthcare, family planning, and care to the normal and expanding family throughout pregnancy, labor, delivery, and post-delivery. *(Office of the Secretary of Family and Social Services; 405 IAC 5-22-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-22-4 Certified nurse practitioner services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. Medicaid reimbursement is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification. *(Office of the Secretary of Family and Social Services; 405 IAC 5-22-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-22-5 Audiology, occupational, and physical therapy and speech pathology; reimbursement
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 5. Audiology, occupational and physical therapy, and speech pathology may be reimbursed directly to an individual provider by Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-22-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-22-6 Occupational, physical, and respiratory therapy and speech pathology; criteria for prior authorization
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 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 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), which are included in the facility's per diem rate.
(7) Physical therapy, occupational therapy, and respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in sections 8, 10, and 11 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 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 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) Therapy for rehabilitative services will be covered for a recipient no longer than two (2) years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy. Habilitative services for a recipient under eighteen (18) years of age may be prior authorized for a longer period on a case-by-case basis. Respiratory therapy services may be prior authorized for a longer period of time on a case-by-case basis.
(7) Maintenance therapy is not a covered service.
(8) When a recipient 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 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) Therapy services will not be approved for more than one (1) hour per day per type of therapy.

(11) A request for therapy services, which would duplicate other services provided to a patient, 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)

405 IAC 5-22-7 Audiology services

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

Sec. 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 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 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. 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 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 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 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 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.

(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 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, 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)

405 IAC 5-22-8 Physical therapy services

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

Sec. 8. Physical therapy services are subject to the following restrictions:
(1) The physical therapy service must be performed by a licensed physical therapist or certified physical therapist's assistant under the direct supervision of a licensed physical therapist or physician as defined in 844 IAC 6-1-2(e) for reimbursement. Only the activities in this subdivision related to the therapy can be performed by someone other than a licensed therapist or certified 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(e).
(3) Evaluations and reevaluations are limited to three (3) hours of service per recipient evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include physical therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.
(4) Physical therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) hours, sessions, or visits in thirty (30) calendar days without prior authorization. This exception includes the provision of splints, crutches, and canes. Prior authorization must be obtained for additional services.
(5) Physical therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3341; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1902; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-

IR-405070311RFA)

405 IAC 5-22-9 Speech pathology services

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

Sec. 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.
(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, 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)

405 IAC 5-22-10 Respiratory therapy services

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

Sec. 10. Respiratory therapy services are subject to the following restrictions:
(1) The respiratory therapy service will only be reimbursed 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, 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)

405 IAC 5-22-11 Occupational therapy services

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

Sec. 11. Occupational therapy services are subject to the following restrictions:
(1) The occupational therapy service must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Evaluation must be performed by the registered occupational therapist for reimbursement.
(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 patient'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 ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) hours, sessions, or visits in thirty (30) calendar days without prior authorization. This exception includes the provision of splints, crutches, and canes. Prior authorization must be obtained for additional services.

(7) Occupational therapy services provided by a nursing facility or large private or small ICF/MR, 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)

Rule 23. Vision Care Services

405 IAC 5-23-1 Reimbursement limitations

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 25-24-1-4

Sec. 1. Medicaid reimbursement is available for vision care services as defined in IC 25-24-1-4 rendered by a licensed provider within the scope of his or her license subject to the limitations set out in this rule. Optical supplies are covered when prescribed by an ophthalmologist or optometrist when dispensed within the limitations listed in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-23-1; 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)*

405 IAC 5-23-2 Initial examinations

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 25-24-1-4

Sec. 2. (a) Reimbursement for the initial vision care examination will be limited to one (1) examination per year for a recipient under nineteen (19) years of age and one (1) examination every two (2) years for a recipient nineteen (19) 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. Such 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 color vision, depth perception, or 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)

405 IAC 5-23-3 Covered vision care services

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

405 IAC 5-23-4 Frames and lenses; limitations

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; 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 head, neck, face, or 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, rose A, pink 1, soft lite, cruxite, and 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 under nineteen (19) 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 control, for example, fire, theft, or automobile accident. The documentation of the extenuating circumstances must be maintained in the provider's office and shall be subject to postpayment review and audit.

(6) Reimbursement for eyeglasses provided to a recipient nineteen (19) years of age or over is limited to a maximum of one (1) pair every two (2) 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 or *[sic., 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)*

405 IAC 5-23-5 Contact lenses

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 25-24-1-4

Sec. 5. Contact lenses are covered only when medical necessity is documented and are not covered for cosmetic purposes. Documentation of such medical necessity must be maintained in the provider's office and shall be subject to postpayment review and audit. *(Office of the Secretary of Family and Social Services; 405 IAC 5-23-5; 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)*

405 IAC 5-23-6 Prior authorization

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 25-24-1-4

Sec. 6. Prior authorization is not required for vision care services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-23-6; 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)*

Rule 24. Pharmacy Services

405 IAC 5-24-1 Reimbursement policy

Authority: IC 12-8-6-5; 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)*

405 IAC 5-24-2 "Pharmacy services" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. As used in this rule, "pharmacy services" means legend drugs, nonlegend drugs included on the Medicaid nonlegend drug formulary developed in coordination with the Indiana Medicaid Drug Utilization Review (DUR) board, insulin, nutritional supplements, food supplements, and infant formulas. Pharmacy services do not include the following:
(1) Nonlegend drugs (except insulin) not included on the Medicaid nonlegend drug formulary.
(2) Any other products offered for sale or rent by a pharmacy provider except legend drugs, nonlegend drugs included on the Medicaid nonlegend drug formulary, insulin, and nutritional supplements, food supplements, and infant formulas.
(Office of the Secretary of Family and Social Services; 405 IAC 5-24-2; 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)

405 IAC 5-24-3 Coverage of legend drugs
Authority: IC 12-8-6-5; 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)

405 IAC 5-24-4 Reimbursement for legend drugs
Authority: IC 12-8-6-5; 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 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 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)

405 IAC 5-24-5 Reimbursement for nonlegend drugs

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

Sec. 5. (a) The office shall reimburse pharmacy providers for the cost and dispensation of nonlegend (over-the-counter) drugs included on the Medicaid nonlegend drug formulary as provided for in this section.

(b) The office shall reimburse for nonlegend drugs, except insulin, at the lowest of the following rates:

(1) One hundred fifty percent (150%) of the state maximum allowable cost, as set out in the Medicaid Pharmacy Provider Manual and amendments thereto, for the drug in the quantity dispensed, as of the date dispensed.

(2) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

(c) The office shall reimburse for insulin at the estimated acquisition cost (EAC) of the drug, plus any applicable Medicaid dispensing fee. For purposes of this subsection, EAC is defined in section 4(b) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-5; 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; filed Nov 23, 2005, 11:30 a.m.: 29 IR 1212; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-24-6 Dispensing fee

Authority: IC 12-8-6-5; 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) For purposes of this rule, the Indiana Medicaid dispensing fee maximum is four dollars and ninety cents ($4.90) per legend drug.

(b) A maximum of one (1) dispensing fee per month is allowable per recipient per drug order for legend drugs provided to Medicaid recipients 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.:*

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405 IAC 5-24-7 Copayment for legend and nonlegend drugs
Authority: IC 12-8-6-5; 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 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 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, 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)

405 IAC 5-24-8 Prior authorization; brand name drugs
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 8. (a) Prior authorization is required for a brand name drug that:

(1) is subject to generic substitution under Indiana law; and

(2) the prescriber has indicated is "brand medically necessary" either orally or in writing on the prescription or drug order.

(b) In order for prior authorization to be granted for a brand name drug in such instances, the prescriber must:

(1) indicate on the prescription or drug order, in the prescriber's own handwriting, the phrase "brand medically necessary"; and

(2) seek prior authorization by substantiating the medical necessity of the brand name drug as opposed to the less costly generic equivalent.

The prior authorization number assigned to the approved request must be included on the prescription or drug order issued by the prescriber or relayed to the dispensing pharmacist by the prescriber if the prescription is orally transmitted. The office may exempt specific drugs or classes of drugs from the prior authorization requirement, based on cost or therapeutic considerations. Prior authorization will be determined in accordance with the provisions of 405 IAC 5-3 and 42 U.S.C. 1396r-8(d)(5). *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; 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)*

405 IAC 5-24-8.5 Prior authorization; other drugs (Voided)

Sec. 8.5. *(Voided by P.L.101-2005, SECTION 9, effective July 1, 2005.)*

405 IAC 5-24-8.6 Prior authorization limitations and other; antianxiety, antidepressant, or antipsychotic agents (Voided)

Sec. 8.6. *(Voided by P.L.101-2005, SECTION 9, effective July 1, 2005.)*

405 IAC 5-24-9 Food supplements, nutritional supplements, and infant formulas
Authority: IC 12-8-6-5; 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 or the recipient'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)*

405 IAC 5-24-10 Medical and nonmedical supply items for long term care facility residents
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 10. The cost of both medical and nonmedical supply items is included in the per diem rate for long term care facilities. Under no circumstances shall medical or nonmedical supplies and equipment be billed through a pharmacy or other provider. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-10; 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)*

405 IAC 5-24-11 Limitations on quantities dispensed and frequency of refills (Voided)

Sec. 11. *(Voided by P.L.101-2005, SECTION 9, effective July 1, 2005.)*

405 IAC 5-24-12 Risk-based managed care
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-6; IC 12-15-35-46; IC 12-15-35-47

Sec. 12. The use of prior authorization programs or formularies in risk-based managed care shall be subject to IC 12-15-35-46 and IC 12-15-35-47 and are not governed by this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-12; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1614; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-24-13 Legend and nonlegend solutions for nursing facility residents
Authority: IC 12-8-6-5; 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, in all forms and for all uses, are included in the per diem rate for nursing facilities. When these drugs 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. *(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)*

Rule 25. Physician Services

405 IAC 5-25-1 Applicability

Authority: IC 12-8-6-3; IC 12-8-6-5; 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, except as provided in this rule. Medical services provided directly to a recipient 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)*

405 IAC 5-25-2 Reimbursement exclusions and limitations

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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, these circumstances must be well documented in the hospital record and 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 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 four (4) per month or twenty (20) per year 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)*

405 IAC 5-25-3 Physician's written order, plan of treatment; when required
Authority: IC 12-8-6-3; IC 12-8-6-5; 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. (a) All Medicaid covered services other than transportation and those services provided by chiropractors, dentists, optometrists, podiatrists, and psychologists certified for private practice require a physician's written order or prescription.

(b) A plan of treatment developed by a physician, which must be renewed every sixty (60) days, is required in addition to a written order for the following services:

(1) Home health services.

(2) All therapy services, including:

(A) physical;

(B) speech pathology;

(C) audiology; and

(D) occupational, respiratory, and psychiatric or psychological.

(Office of the Secretary of Family and Social Services; 405 IAC 5-25-3; 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)

405 IAC 5-25-4 Injections administered by physicians
Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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)*

405 IAC 5-25-5 Inpatient services; reimbursement limitations
Authority: IC 12-8-6-3; IC 12-8-6-5; 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) Any physician services rendered during inpatient days that require prior authorization and paid under the level of care methodology defined in 405 IAC 1-10.5 that were not prior authorized will not be reimbursed.

(b) Reimbursement for any inpatient physician service rendered during a hospital stay that is subsequently found not to be medically necessary is subject to recoupment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-25-5; 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)*

Rule 26. Podiatric Services

405 IAC 5-26-1 Scope
Authority: IC 12-8-6-3; IC 12-8-6-5; 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. Subject to the limitations set out in this rule, Medicaid reimbursement is available for podiatric services performed within the scope of the practice of the podiatric profession as defined by Indiana law. Services covered shall include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders, subject to the restrictions and limitations set out in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-26-1; 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)*

405 IAC 5-26-2 General restrictions

Authority: IC 12-8-6-3; IC 12-8-6-5; 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. Podiatric services are subject to the following restrictions:

(1) In an emergency situation, for services requiring prior authorization, the authorization must be obtained within forty-eight (48) hours, not including Saturdays, Sundays, and legal holidays.

(2) Any podiatrist services rendered during inpatient days that were not appropriately prior authorized or were subsequently found to be not medically necessary will not be reimbursed. Prior authorization is required for hospitals stays as outlined in 405 IAC 5-21.

(3) Any podiatrist services rendered during an outpatient visit that were not appropriately prior authorized or were subsequently found to be not medically necessary will not be reimbursed.

(4) Consultation services rendered by a podiatrist in a nursing facility are not covered when performed on patients on a routine basis for screening purposes, except in those cases where a specific foot ailment is involved.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-2; 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)

405 IAC 5-26-3 Routine foot care; restrictions

Authority: IC 12-8-6-3; IC 12-8-6-5; 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. (a) Routine foot care includes the following:

(1) Cutting or removal of corns, calluses, or warts (including plantar warts).

(2) Trimming of nails, including mycotic nails.

(3) Treatment of a fungal (mycotic) infection of the toenail is routine foot care only when:

(A) clinical evidence of infection of the toenail is present; and

(B) compelling medical evidence exists documenting that the patient either has a marked limitation of ambulation requiring active treatment of the foot or, in the case of a nonambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment.

(b) A maximum of six (6) routine foot care services per year are covered and only when a patient:

(1) has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and

(2) the systemic condition has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet.

Prior authorization for routine foot care is not required. However, no more than six (6) visits per year are covered. The patient must have been seen by a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the six (6) month period prior to the rendering of routine foot care services. Documentation that the treatment or evaluation occurred within six (6) months prior to routine foot care must be included with the claim, as well as documentation of the nature of the systemic condition and the foot condition being treated. *(Office of the Secretary of Family and Social Services; 405 IAC 5-26-3; 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)*

405 IAC 5-26-4 Laboratory or x-ray services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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) Medicaid will reimburse a podiatrist for laboratory or x-ray services only if the services are rendered by or under the personal supervision of the podiatrist. Services ordered by a podiatrist, but performed by a laboratory or x-ray facility, shall be billed directly to Medicaid by the laboratory or x-ray facility. The podiatrist may be reimbursed for handling or conveyance of a specimen sent to an outside laboratory in accordance with 405 IAC 5-18.

(b) Medicaid reimbursement is not available for comparative foot x-rays, unless prior authorized.

(c) Medicaid reimbursement is available for the following lab and x-ray services billed by a podiatrist:

(1) Cultures for foot infections and mycotic (fungal) nails for diagnostic purposes.

(2) Sensitivity studies for treatment of infection processes.
(3) Medically necessary presurgical testing.
(Office of the Secretary of Family and Social Services; 405 IAC 5-26-4; 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)

405 IAC 5-26-5 Prior authorization
Authority: IC 12-8-6-3; IC 12-8-6-5; 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 under twenty-one (21) years of age.
(3) When a podiatrist fits or supplies orthopedic shoes for a recipient 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)*

405 IAC 5-26-6 Orthotic services
Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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)*

405 IAC 5-26-7 Podiatric office visits
Authority: IC 12-8-6-3; IC 12-8-6-5; 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.
(2) New patient office visits are limited to one (1) per recipient, 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)

405 IAC 5-26-8 Doppler evaluations

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 ultrasonic measurement of blood flow (Doppler) providing that prior authorization has been obtained for the proposed medical procedure and subject to the following limitations:

(1) A preoperative diagnosis of diabetes mellitus peripheral vascular disease or peripheral neuropathy.

(2) The ultrasonic measurement is for preoperative podiatric evaluation.

(3) The ultrasonic measurement cannot be used for routine screening purposes.

(4) The ultrasonic measurement cannot be used as an evaluation of routine foot care procedures, including such services as removal or trimming of corns, calluses, and nails.

(5) The preoperative Doppler evaluation limited to one (1) per year.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-8; 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)

405 IAC 5-26-9 Surgical procedures; reimbursement

Authority: IC 12-8-6-3; IC 12-8-6-5; 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) All surgical procedures on one (1) foot or both feet performed on the same date will be paid at one hundred percent (100%) of the Medicaid allowance for the major procedure and fifty percent (50%) of the Medicaid allowance for subsequent procedures.

(b) If the surgery is performed on both feet, and if the surgery on the second foot is performed at least five (5) days following surgery on the first foot, one hundred percent (100%) allowance is payable for the second surgery.

(c) If the major surgical procedure is performed on one (1) foot, a time period of five (5) days must elapse before subsequent surgery on the same foot would again be paid at one hundred percent (100%) of Medicaid allowable reimbursement. Surgery performed sooner than five (5) days will be paid at fifty percent (50%) of Medicaid allowable reimbursement.

(d) If the major surgical procedure is performed on one (1) toe, a time period of thirty (30) days must elapse before subsequent surgery on the same toe would again be paid at one hundred percent (100%) of Medicaid allowable reimbursement. Surgery performed sooner than thirty (30) days will be reimbursed at fifty percent (50%) of Medicaid allowable reimbursement.

(e) Podiatric surgical procedures, including diagnostic surgical procedures, cannot be fragmented and billed separately. Such procedures generally are included in the major procedure. Such procedures may include, but are not limited to, the following:

(1) Scope procedures used for the surgical procedure approach.

(2) Arthroscopy or arthrotomy procedures in the same area as a major joint procedure unless claim documents a second incision was made.

(3) Local anesthesia administered to perform the surgical or diagnostic procedure.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-9; 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)

405 IAC 5-26-10 Surgical procedures; confirmatory consultations

Authority: IC 12-8-6-3; IC 12-8-6-5; 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)*

Rule 27. Radiology Services

405 IAC 5-27-1 Reimbursement limitations

Authority: IC 12-8-6-5; 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, free-standing clinics, and surgical centers for services provided to recipients 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)

405 IAC 5-27-2 Utilization criteria

Authority: IC 12-8-6-5; 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. Criteria for utilization of radiological services shall include consideration of the following:

(1) Evidence that this radiologic procedure is necessary for the appropriate treatment of illness or injury.

(2) X-rays of the spinal column are limited to cases of acute documented injury or a medical condition where interpretation of x-ray films would make a direct impact on the medical/surgical treatment.

(3) Medicaid reimbursement is available for x-rays of the extremities and spine for the study of neuromusculoskeletal conditions.

(4) Medicaid reimbursement is not available for radiology examinations of any body part taken as a routine study not necessary to the diagnosis or treatment of a medical condition. Situations generally not needing radiologic services include, but are not limited to, the following:

(A) Pregnancy.

(B) Research studies.

(C) Screening.

(D) Routine physical examinations or check-ups.

(E) Premarital examinations.

(F) Fluoroscopy without films.

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3351; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-27-3 Computerized tomography; general

Authority: IC 12-8-6-5; 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. (a) Medicaid reimbursement may be available for diagnostic examination of the head (head scan) and of other parts of the body (body scans) performed by computerized tomography (CT) scanners, subject to the following restrictions:

(1) The scan should be reasonable and necessary for the individual patient.

(2) The use of a CT scan must be found to be medically appropriate considering the patient's symptoms and preliminary diagnosis.

(3) Reimbursement will be made only for CT scans that have been performed on equipment that has been certified by the food and drug administration.

(4) Whole abdomen, or whole pelvis on greater than twenty (20) cuts will not be reimbursed except in staging cancer for treatment evaluation.

(b) Prior authorization is not required for CT scans. *(Office of the Secretary of Family and Social Services; 405 IAC 5-27-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3351; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-27-4 Nuclear medicine

Authority: IC 12-8-6-5; 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. Medicaid reimbursement is available for radionuclide bone scans when performed for the detection and evaluation of suspected or documented bone disease. *(Office of the Secretary of Family and Social Services; 405 IAC 5-27-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3351; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-27-5 Upper gastrointestinal studies

Authority: IC 12-8-6-5; 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. (a) Medicaid reimbursement is available for upper gastrointestinal (GI) studies when performed for the detection and evaluation of diseases of the esophagus, stomach, and duodenum.

(b) An upper GI study is not a covered service for a patient with a history of duodenal or gastric ulcer disease unless recently symptomatic.

(c) An upper GI study is not a covered service in the preoperative cholecystectomy patient unless symptoms indicate an upper GI abnormality in addition to the cholelithiasism or if the etiology of the abdominal pain is uncertain. *(Office of the Secretary of Family and Social Services; 405 IAC 5-27-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3351; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-27-6 Sonography

Authority: IC 12-8-6-5; 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 sonography performed during pregnancy when warranted by one (1) or more of the following conditions:

(1) Early diagnosis of ectopic or molar pregnancy.

(2) Placental localization associated with abnormal bleeding.

(3) Fetal postmaturity syndrome.

(4) Suspected multiple births.

(5) Suspected congenital anomaly.

(6) Polyhydramnios or oligohydramnios.

(7) Fetal age determination if necessitated by:
(A) discrepancy in size versus fetal age; or
(B) lack of fetal growth or suspected fetal death.
(8) Guide for amniocentesis.
(b) Reimbursement is available for sonography for fetal age determination prior to therapeutic abortions when the age of the fetus cannot be determined by the patient's history and physical examination and the information is essential for the selection of the abortion method. *(Office of the Secretary of Family and Social Services; 405 IAC 5-27-6; 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)*

Rule 28. Medical and Surgical Services

405 IAC 5-28-1 Reimbursement limitations

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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 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 *[sic., 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 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)*

405 IAC 5-28-2 Medical diagnostic procedures
Authority: IC 12-8-6-3; IC 12-8-6-5; 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. Medical diagnostic services may not be fragmented and billed separately. Such procedures include, but are not limited to, electromyography, electrocardiography, and muscle testing procedures. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-2; 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)*

405 IAC 5-28-3 Cardiac pacemaker
Authority: IC 12-8-6-3; IC 12-8-6-5; 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. (a) Medicaid reimbursement is available for single-chamber cardiac pacemaker implantations. Medicaid reimbursement is subject to the restrictions in this section.
(b) Reimbursement is available for implantation of a single-chamber cardiac pacemaker provided that the conditions are:
(1) chronic or recurrent; and
(2) not due to transient causes, such as acute myocardial infarction, drug toxicity, or electrolyte imbalance.
(Office of the Secretary of Family and Social Services; 405 IAC 5-28-3; 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)

405 IAC 5-28-4 Single-chamber cardiac pacemaker implantation
Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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)

405 IAC 5-28-5 Dual-chamber cardiac pacemaker implantation
Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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 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, meeting requirements of section 4 of this rule, must be based upon the individual needs and characteristics of that recipient weighing the magnitude and likelihood of anticipated benefits against the magnitude and likelihood of disadvantages of the recipient. *(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)*

405 IAC 5-28-6 Monitoring of pacemakers

Authority: IC 12-8-6-3; IC 12-8-6-5; 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) Medicaid reimbursement is available for clinic and telephone monitoring of cardiac pacemakers based upon the restrictions in this section.

(b) Frequency of monitoring, unless sufficiently documented by the physician on the Medicaid medical claim form, shall not exceed the following:

(1) For clinic monitoring of lithium battery pacemakers with single-chamber pacemakers, twice in the first six (6) months following implant, then once every twelve (12) months.

(2) For clinic monitoring of lithium battery pacemakers with dual-chamber pacemakers, twice in the first six (6) months following implant, then once every six (6) months.

(3) For telephone monitoring with single-chamber pacemaker following the first month of the implant, once every two (2) weeks.

(4) For telephone monitoring with single-chamber pacemaker following the second month of the implant through the thirty-sixth month, once every eight (8) weeks.

(5) For telephone monitoring with single-chamber pacemaker following the thirty-seventh month of the implant through failure, once every four (4) weeks.

(6) For telephone monitoring with dual-chamber pacemaker following the first month of the implant, once every two (2) weeks.

(7) For telephone monitoring with dual-chamber pacemaker following the second through the sixth month of the implant, once every four (4) weeks.

(8) For telephone monitoring with dual-chamber pacemaker following the seventh through the thirty-sixth month of the implant, once every eight (8) weeks.

(9) For telephone monitoring with dual-chamber pacemaker following the seventh through the thirty-seventh month through failure of the implant, once every four (4) weeks.

(c) The claim form must state the date of the pacemaker insertion and the type of pacemaker monitored. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-6; 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)*

405 IAC 5-28-7 Abortion

Authority: IC 12-8-6-3; IC 12-8-6-5; 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. Medicaid reimbursement is available for abortions only if performed to preserve the life of the pregnant woman or in other circumstances if the abortion is required to be covered by Medicaid under federal law. Termination of an ectopic pregnancy is not considered an abortion. 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 5-28-7; 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)*

405 IAC 5-28-8 Sterilization

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 must be twenty-one (21) years of age or older at the time the informed consent form is signed.

(3) The patient must be neither mentally incompetent nor institutionalized.

(4) The patient 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)

405 IAC 5-28-9 Hysterectomy

Authority: IC 12-8-6-3; IC 12-8-6-5; 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, or recipient's representative, but is not required where the recipient is already sterile or where a life-threatening emergency situation exists. Where the hysterectomy is performed on an already sterile patient, the physician who performs the hysterectomy must certify in writing that the recipient 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 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)

405 IAC 5-28-10 Chemotherapy

Authority: IC 12-8-6-3; IC 12-8-6-5; 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) Outpatient administration of chemotherapy and costs related to this therapy, including catherization, physician's visit, cost of drug and solutions, pump regulators, and servicing, will be covered and do not require prior authorization.

(b) Chemotherapy services provided by a home health agency are subject to the prior authorization criteria at 405 IAC 5-16-3.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-10; 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)

405 IAC 5-28-11 Hyperbaric oxygen therapy

Authority: IC 12-8-6-3; IC 12-8-6-5; 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. 11. (a) Medicaid reimbursement is available for hyperbaric oxygen (HBO) therapy for the following conditions:

(1) Acute carbon monoxide intoxication.

(2) Decompression illness.

(3) Gas embolism.

(4) Gas gangrene.

(5) Acute traumatic peripheral ischemia.

(6) Crush injuries and suturing of severed limbs; as in the previous conditions, HBO therapy would be an adjunctive treatment

when loss of function, limb, or life is threatened.
(7) Meleney ulcers; the use of hyperbaric oxygen in any other type of cutaneous ulcer is not covered.
(8) Acute peripheral arterial insufficiency.
(9) Preparation and preservation of compromised skin grafts.
(10) Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management.
(11) Osteoradionecrosis as an adjunct to conventional treatment.
(12) Soft tissue radionecrosis as an adjunct to conventional treatment.
(13) Cyanide poisoning.
(14) Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.
(15) Acute cerebral edema.
(b) Medicaid reimbursement is not available for therapy by HBO for the following conditions or services:
(1) Topical application of oxygen.
(2) Cutaneous, decubitus, and stasis ulcers.
(3) Chronic peripheral vascular insufficiency.
(4) Anaerobic septicemia and infection other than clostridial.
(5) Skin burns (thermal).
(6) Senility.
(7) Myocardial infarction.
(8) Cardiogenic shock.
(9) Sickle cell crisis.
(10) Acute thermal and chemical pulmonary damage, including smoke inhalation with pulmonary insufficiency.
(11) Acute or chronic cerebral vascular insufficiency.
(12) Hepatic necrosis.
(13) Aerobic septicemia.
(14) Nonvascular causes of chronic brain syndrome, including Pick's disease, Alzheimer's disease, and Korsakoff's disease.
(15) Tetanus.
(16) Systemic aerobic infection.
(17) Organ transplantation.
(18) Organ storage.
(19) Pulmonary emphysema.
(20) Exceptional blood loss anemia.
(21) Multiple sclerosis.
(22) Arthritic diseases.
(c) Hyperbaric oxygen therapy shall be clinically practical and shall not be a replacement for other standard successful therapeutic measures. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3356; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

Rule 29. Services Not Covered by Medicaid

405 IAC 5-29-1 Noncovered services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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. The following services are not covered by Medicaid:
(1) Services that are not medially *[sic.]* 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 deferns). *[sic.]* 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) Multifacted *[sic.]* craniofacial abnormalities due to congenital malformation or maldevelopment, for example, Pierre Robin Syndrome.
(B) A recipient 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 5-21.
(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 5-19.
(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)

Rule 30. Transportation Services

405 IAC 5-30-1 Reimbursement restrictions

Authority: IC 12-8-6-3; IC 12-8-6-5; 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, 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 has been discharged from one (1) hospital for the purpose of admission to another hospital.
(C) Transportation for patients on renal dialysis or those residing in nursing homes.
(D) Accompanying parent or recipient 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 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 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.
(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 or a party acting on the recipient'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 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 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)

405 IAC 5-30-2 Copayments for transportation services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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 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 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 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, 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)

405 IAC 5-30-3 Noncovered transportation services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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, 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.
(B) An interested individual or neighbor of the recipient.
(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 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 residence to place of storage, or from the place of storage to the recipient's residence.

(8) Charges for use of red lights and siren in emergency ambulance call.
(9) All interhospital transportation services, except when the recipient 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 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)

405 IAC 5-30-4 Prior authorization

Authority: IC 12-8-6-3; IC 12-8-6-5; 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, 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)

405 IAC 5-30-5 Ambulance services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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 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)

405 IAC 5-30-6 Intrastate wheelchair/nonambulatory services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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 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 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)

405 IAC 5-30-7 Intrastate commercial ambulatory services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 must travel to or from an Indiana Medicaid covered service. Commercial ambulatory services are those services provided to ambulatory recipients 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 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 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)

405 IAC 5-30-8 Reimbursement for additional passengers

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 (½) 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 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 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 is in need of medical services and because of his condition must have an assistant to travel with him or her and/or stay with him in the place of medical service, the commercial ambulatory services or the nonambulatory services base code will be reimbursed for the recipient and the accompanying multiple passenger code will be reimbursed for

the assistant.

(3) When more than one (1) recipient 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, plus mileage and waiting codes, where appropriate. Payment for the second and subsequent recipients is available for one-half (½) 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)

405 IAC 5-30-9 Reimbursement for family member transportation services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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. 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 and children in which the recipient resides must authorize all family member transportation. *(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)*

405 IAC 5-30-10 Reimbursement for other transportation services

Authority: IC 12-8-6-3; IC 12-8-6-5; 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 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 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)*

Rule 31. Nursing Facility Services

405 IAC 5-31-1 Reimbursement

Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-31-1.1 "Nursing facility services" defined

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

Sec. 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 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)*

405 IAC 5-31-2 "Skilled care services" defined (Repealed)

Sec. 2. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324)*

405 IAC 5-31-3 "Intermediate care services" defined (Repealed)

Sec. 3. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324)*

405 IAC 5-31-4 Per diem services

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

Sec. 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 condition requires isolation for health reasons, such as communicable disease.

(B) The recipient 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, 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; and

(G) traction equipment;

(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 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 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 in all forms and for all uses.

(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)

405 IAC 5-31-4.5 Per diem services, state nursing facility

Authority: IC 12-8-6-5; 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 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 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 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)

405 IAC 5-31-5 Legend and prescription items
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 5. (a) All covered legend and nonlegend drugs must be prescribed by a physician. Facilities cannot require recipients 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)*

405 IAC 5-31-6 Personal care items
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. Personal care or comfort items as defined in 42 CFR 483.10(c)(8)(ii) and 42 CFR 483.10(c)(8)(iii) are not covered under Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-31-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-31-7 Limitations on nursing services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 7. Routine nursing services are reimbursed by Medicaid within the per diem rate. Such services must be provided by a registered nurse, a licensed practical nurse, or a nurse's aide. *(Office of the Secretary of Family and Social Services; 405 IAC 5-31-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-31-8 Reservation of nursing facility beds
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 8. (a) Although it is not mandatory for facilities to reserve beds, Medicaid will reimburse for reserving beds for Medicaid recipients at one-half (½) the per diem rate provided that the criteria as set out in this section are met.

(b) Hospitalization must be ordered by the physician for treatment of an acute condition that cannot be treated in the nursing facility. The total 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 attending physician and as indicated in the recipient's plan of care. The total length of time allotted for therapeutic leaves in any calendar year is thirty (30). The leave days need not be consecutive.

(d) Although prior authorization by the office is not required to reserve a bed, a physician's order for the hospitalization or therapeutic leave must be on file in the facility.

(e) Requests for reimbursement of nursing facility services shall be expressed in units of full days. A day begins at midnight and ends twenty-four (24) hours later. The midnight-to-midnight method must 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.

(f) In no instance will Medicaid reimburse a nursing facility for reserving beds for Medicaid recipients 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 recipient 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 5-31-8; filed Jul 25, 1997, 4:00 p.m.:*

20 IR 3362; filed Sep 27, 1999, 8:55 a.m.: 23 IR 322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:36 p.m.: 25 IR 2475; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-31-9 Prior authorization for services rendered outside the state nursing facility
Authority: IC 12-8-6-5; 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)

Rule 32. Rehabilitation Unit

405 IAC 5-32-1 Severity of illness criteria
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. The following criteria shall demonstrate the inability to function independently with demonstrated impairment:
(1) Cognitive function (attention span, memory, or intelligence).
(2) Communication (aphasia with major receptive or expressive dysfunction).
(3) Continence (bladder or bowel).
(4) Mobility (transfer, walk, climb stairs, or wheelchair).
(5) Pain management (pain behavior limits functional performance).
(6) Perceptual motor function (spatial orientation or depth or distance perception).
(7) Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis).
(Office of the Secretary of Family and Social Services; 405 IAC 5-32-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-32-2 Intensity of service criteria
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. Intensity of service criteria shall be as follows:
(1) Multidisciplinary team evaluation at least every two (2) weeks.
(2) Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):
(A) Occupational therapy.
(B) Speech therapy.
(3) Participation in a rehabilitation program under the direction of a qualified physician.
(4) Skilled rehabilitative nursing care or supervision required at least daily.
(Office of the Secretary of Family and Social Services; 405 IAC 5-32-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-32-3 Discharge criteria

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

Sec. 3. Discharge criteria for consideration may include the following:
(1) Evidence in record that patient has achieved stated goals.
(2) Medical complications preclude intensive rehabilitative effort.
(3) Multidisciplinary therapy no longer needed.
(4) No additional functional improvement is anticipated.
(5) Patient's functional status has remained unchanged for fourteen (14) days.

(Office of the Secretary of Family and Social Services; 405 IAC 5-32-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

Rule 33. Acute Care Hospital Admission

405 IAC 5-33-1 Adult medical surgical criteria

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

Sec. 1. Day of admission appropriateness shall be as follows:
(1) Severity of illness criteria:
(A) sudden onset of unconsciousness or disorientation (coma or unresponsiveness);
(B) pulse rate:
(i) less than fifty (50) per minute; or
(ii) greater than one hundred forty (140) per minute;
(C) blood pressure:
(i) systolic less than ninety (90) or greater than two hundred (200) millimeters mercury; or
(ii) diastolic less than sixty (60) or greater than one hundred twenty (120) millimeters mercury;
(D) acute loss of sight or hearing;
(E) acute loss of ability to move body part;
(F) persistent fever equal to or greater than one hundred (100) (p.o) or greater than one hundred one (101) (R) for more than five (5) days;
(G) active bleeding;
(H) severe electrolyte/blood gas abnormality, including any of the following:
(i) Na < 123 mEq/L
Na > 156 mEq/L
(ii) K < 2.5 mEq/L
K > 6.0 mEq/L
(iii) CO_2 combining power (unless chronically abnormal) < 20 mEq/L
CO_2 combining power (unless chronically abnormal) > 36 mEq/L
(iv) Blood pH < 7.30
Blood pH > 7.45;
(I) acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, or breathe); must also meet intensity of service criterion simultaneously in order to certify; do not use for back pain;
(J) EKG evidence of acute ischemia; must be suspicion of a new MI; or
(K) wound dehiscence of evisceration.
(2) Intensity of service:
(A) intravenous medications and/or fluid replacement (does not include tube feedings);
(B) surgery or procedure scheduled within twenty-four (24) hours requiring:
(i) general or regional anesthesia; or

(ii) use of equipment, facilities, or procedure available only in a hospital;
(C) vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);
(D) chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;
(E) treatment in an intensive care unit;
(F) intramuscular antibiotics at least every eight (8) hours; and
(G) intermittent or continuous respirator use at least every eight (8) hours.
(3) Criteria of appropriateness of day of care shall include the following:
(A) Medical services:
(i) procedure in operating room that day;
(ii) scheduled for procedure in operating room the next day, requiring preoperative consultation or evaluation;
(iii) cardiac catheterization that day;
(iv) angiography that day;
(v) biopsy of internal organ that day;
(vi) thoracentesis or paracentesis that day;
(vii) invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day;
(viii) any test requiring strict dietary control for the duration of the diet;
(ix) new or experimental treatment requiring frequent dose adjustments under direct medical supervision;
(x) close medical monitoring by a doctor at least three (3) times daily (observations must be documented in record); or
(xi) postoperative day for any procedure covered in item (i) or (iii) through (vii).
(B) Nursing/life support services:
(i) respiratory care–intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB) at least three (3) times daily;
(ii) parenteral therapy–intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications);
(iii) continuous vital sign monitoring, at least every thirty (30) minutes, for at least four (4) hours;
(iv) IM and/or SC injections at least twice daily;
(v) intake and output measurement;
(vi) major surgical wound and drainage care (chest tubes, T-tubes, hemovacs, Penrose drains); or
(vii) close medical monitoring by nurse at least three (3) times daily, under doctor's orders.
(C) Patient condition:
(i) within twenty-four (24) hours before day of review inability to void or move bowels (past twenty-four (24) hours) not attributable to neurologic disorder;
(ii) within forty-eight (48) hours before day of review:
(AA) transfusion due to blood loss;
(BB) ventricular fibrillation or ECG evidence of acute ischemia, as stated in progress note or in ECG report;
(CC) fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally), if patient was admitted for reasons other than fever;
(DD) coma–unresponsiveness for at least one (1) hour;
(EE) acute confusional state, not due to alcohol withdrawal;
(FF) acute hematologic disorders, significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis yielding signs or symptoms; or
(GG) progressive acute neurologic difficulties; and
(iii) within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke).

(Office of the Secretary of Family and Social Services; 405 IAC 5-33-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-33-2 Pediatric AEP admission criteria

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

Sec. 2. Day of admission appropriateness shall be as follows:

(1) Severity of illness criteria:

(A) sudden onset of unconsciousness (coma or unresponsiveness) or disorientation;

(B) acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, or urinate);

(C) acute loss of sight or hearing;

(D) acute loss of ability to move body part;

(E) persistent fever (> one hundred (100) degrees orally or > one hundred one (101) degrees rectally) for more than ten (10) days;

(F) active bleeding;

(G) wound dehiscence or evisceration;

(H) severe electrolyte/acid-base abnormality, including any of the following:

(i) Na < 123 mEq/L
Na > 156 mEq/L

(ii) K < 2.5 mEq/L
K > 6.0 mEq/L

(iii) CO_2 combining power (unless chronically abnormal) <20 mEq/L
CO_2 combining power (unless chronically abnormal) > 36 mEq/L

(iv) Arterial pH < 7.30
Arterial pH > 7.45;

(I) hematocrit < thirty percent (30%);

(J) pulse rate outside following ranges (optimally a sleeping pulse for < twelve (12) years old):

2–6 years old	70–200/minute
7–11 years old	60–180/minute
> 12 years old	50–140/minute

(K) blood pressure outside following ranges:

	Systolic	Diastolic
2–6 years old	75–125 mm Hg	40–90 mm Hg
7–11 years old	80–130 mm Hg	45–90 mm Hg
< 12 years old	90–200 mm Hg	60–120 mm Hg

(L) need for lumbar puncture, where this procedure is not done routinely on an outpatient basis;

(M) any conditions not responding to outpatient, including emergency room:

(i) seizures;

(ii) cardiac arrhythmia;

(iii) bronchial asthma or croup;

(iv) dehydration;

(v) encopresis (for clean-out); or

(vi) other physiologic problem (specify);

(N) special pediatric problems:

(i) child abuse;

(ii) noncompliance with necessary therapeutic regimen; or

(iii) need for special observation or close monitoring of behavior, including calorie intake in cases of failure to thrive.

(2) Intensity of service:

(A) surgery or procedure scheduled within twenty-four (24) hours requiring:

(i) general or regional anesthesia; or
(ii) use of equipment, facilities, or procedure available only in a hospital;
(B) treatment in an intensive care unit;
(C) vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);
(D) intravenous medications and/or fluid replacement (does not include tube feedings);
(E) chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;
(F) intramuscular antibiotics at least every eight (8) hours; and
(G) intermittent or continuous respirator use at least eight (8) hours.
(3) Criteria of appropriateness of day of care shall be as follows:
(A) For medical services, the following documented criteria will be used for continued stay reviews; at least one (1) of the criteria must be met for the continued stay to be recertified:
(i) Procedure in operating room that day.
(ii) Procedure scheduled in operating room the next day, requiring preoperative consultation or evaluation.
(iii) If day being reviewed is the day of admission, any procedure among subdivisions *[sic., items]* (iv) through (ix) scheduled for the day after admission unless that procedure is usually done at that facility on a same-day basis.
(iv) Cardiac catheterization that day.
(v) Angiography that day.
(vi) Biopsy of internal organ that day.
(vii) Thoracentesis or paracentesis that day.
(viii) Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day.
(ix) Gastrointestinal endoscopy that day.
(x) Any test requiring strict dietary control for the duration of the diet.
(xi) New or experimental treatment requiring frequent dose adjustments under direct medical supervision.
(xii) Close medical monitoring by a doctor at least three (3) times daily (observations must be documented in record).
Postoperative day for any procedure covered in item (i) or (iv) through (ix).
(B) Nursing/life support services shall be as follows:
(i) Respiratory care–intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB), at least three (3) times daily, Bronkosol with oxygen, oxyhoods, or oxygen tents.
(ii) Parenteral therapy–intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications).
(iii) Continuous vital sign monitoring, at least every thirty (30) minutes for at least four (4) hours.
(iv) IM and/or SC injections at least twice daily.
(v) Intake and/or output measurement.
(vi) Major surgical wound and drainage care, for example, chest tubes, T-tubes, hemovacs, or Penrose drains.
(vii) Traction for fractures, dislocations, or congenital deformities.
(viii) Close medical monitoring by nurse at least three (3) times daily, under doctor's orders.
(C) Patient condition:
(i) within twenty-four (24) hours on or before day of review, inability to void or move bowels, not attributable to neurologic disorder–usually a post-op;
(ii) within forty-eight (48) hours on or before day of review:
(AA) transfusion due to blood loss;
(BB) ventricular fibrillation or ECG evidence of acute ischemia as stated in progress note or in ECG report;
(CC) fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally) if patient was admitted for reason other than fever;
(DD) coma–unresponsiveness for at least one (1) hour;
(EE) acute confusional state, including withdrawal from drugs and alcohol;
(FF) acute hematologic disorders–significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis–yielding signs of symptoms; or

(GG) progressive acute neurologic difficulties; and

(iii) within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke).

(Office of the Secretary of Family and Social Services; 405 IAC 5-33-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3364; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

Rule 34. Hospice Services

405 IAC 5-34-1 Policy

Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-34-2 Provider enrollment

Authority: IC 12-8-6-5; 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 because of the recipient's source of payment.
(g) The provider must demonstrate respect for a recipient's rights by ensuring that the election of hospice services is based on the informed, voluntary consent of the recipient or the recipient's representative.
(h) A hospice provider may discharge a recipient from hospice services only if one (1) or more of the following occurs:
(1) The recipient dies.
(2) The recipient is determined to have a prognosis greater than six (6) months.
(3) The recipient moves out of the hospice's service area.
(4) The safety of the recipient, 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)

405 IAC 5-34-3 Out-of-state providers
Authority: IC 12-8-6-5; 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)*

405 IAC 5-34-4 Hospice authorization and benefit periods
Authority: IC 12-8-6-5; 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 for each hospice benefit period, the provider must submit all of the following documentation on forms approved by the office:
(1) Medicaid recipient election statement.
(2) Medicaid physician certification.
(3) Medicaid plan of care.
(c) Dually-eligible Medicare/Medicaid recipients 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 election of the Medicare hospice benefit. The form must reflect the signature of the recipient or the recipient'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 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 residing at home as Medicare is reimbursing for the hospice care.

(e) Hospice authorization for the Medicaid-only hospice recipient 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. 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 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 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 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 eligibility. The hospice authorization request must be submitted within twelve (12) months of the date of the issuance of the recipient's Medicaid card.

(2) The provider was unaware that the recipient 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 refused or was physically unable to provide the recipient 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 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)*

405 IAC 5-34-4.1 Appeals of hospice authorization determinations

Authority: IC 12-8-6-5; 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 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)*

405 IAC 5-34-4.2 Audit

Authority: IC 12-8-6-5; 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)*

405 IAC 5-34-5 Physician certification

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
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, 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, 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:

(A) the medical director of the hospice program or the physician member of the hospice interdisciplinary group; and

(B) the recipient's attending physician if the recipient 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 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, the Medicaid physician certification form must be included in the recipient's medical chart in the hospice agency and the recipient's medical chart in the nursing facility. *(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)*

405 IAC 5-34-6 Election of hospice services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 6. (a) In order to receive hospice services, a recipient must elect hospice services by filing an election statement with the hospice provider on forms specified by the office.

(b) Election of the hospice benefit requires the recipient 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 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) The recipient or recipient'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.

(d) For Medicaid-only hospice recipient, 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 has revoked the election and wishes to reelect hospice care.

(e) For the dually-eligible Medicare/Medicaid hospice recipient residing in the nursing facility, the hospice agency election form reflecting the Medicare hospice election date and the recipient'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 has revoked the election and wishes to reelect hospice care under the Medicare and Medicaid hospice benefits.

(f) In the event that a recipient or the recipient'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 may elect to receive hospice care intermittently rather than consecutively over the benefit periods.
(3) If a recipient 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 as well as dually-eligible Medicare/Medicaid hospice recipients 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 medical chart in the hospice agency. If the Medicaid hospice recipient resides in a nursing facility, the Medicaid hospice revocation form must be included in the recipient's nursing facility medical chart as well.

(g) A recipient or a recipient'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 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 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 medical chart in the hospice agency. If the Medicaid hospice recipient resides in a nursing facility, this form must be included in the recipient'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)

405 IAC 5-34-7 Plan of care

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 7. (a) When an eligible recipient elects to receive services from a certified hospice provider, the provider shall develop a plan of care. For the Medicaid-only hospice recipients, 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.

(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, the Medicaid hospice plan of care must be included in the recipient's medical chart at the hospice agency. If the Medicaid-only recipient resides in a nursing facility, the Medicaid plan of care must also be included in the recipient's nursing facility medical chart.

(5) For the dually-eligible Medicare/Medicaid hospice recipient 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 nursing facility medical chart.

(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)

405 IAC 5-34-8 Covered services

Authority: IC 12-8-6-5; 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 services provided to the recipient and the recipient's family or other person caring for the recipient.

(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 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 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 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)

405 IAC 5-34-9 Levels of care
Authority: IC 12-8-6-5; 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 who resides in a nursing facility, the nursing facility is considered the recipient'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)*

405 IAC 5-34-10 Location of care
Authority: IC 12-8-6-5; 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 determines the location of care for that recipient. 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 usually lives in his or her private home.
(c) Nursing facility location of care applies if the recipient 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 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)*

405 IAC 5-34-11 Prior authorization for nonhospice services
Authority: IC 12-8-6-5; 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 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)

405 IAC 5-34-12 Reservation of beds for hospice recipients in nursing facilities

Authority: IC 12-8-6-5; 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 at one-half (½) 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 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 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 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 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)*

Rule 35. Case Management Services for Infants and Toddlers with Disabilities

405 IAC 5-35-1 Definitions

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

Sec. 1. (a) The definitions in this section apply throughout this rule.

(b) "IFSP" means the individualized family service plan, a written plan for providing early intervention services to a child eligible for early intervention services and the child's family.

(c) "Service coordination services" means targeted case management services. Providers of targeted case management services are referred to as "service coordinators" in this rule.

(d) "Targeted case management services for infants and toddlers with disabilities" means an active, ongoing process of assisting the infant or toddler and his or her family to identify, access, and utilize early intervention services to benefit the development of the child and to coordinate the services to meet the individual needs of the infant or toddler and his or her family. The term includes the following services:

(1) Coordinating the evaluation activities related to eligibility redetermination.

(2) Assisting families in identifying available services.

(3) Coordinating and monitoring the authorization, scheduling, and performance of assessments and services.

(4) Participating and facilitating in the development, review, and evaluation of the IFSP.

(5) Assisting in the identification and access to available financial support.

(6) Informing families of the availability of advocacy services.

(7) Coordinating and participating in the development of a transition plan for infants and toddlers into, within, and from the early intervention system to preschool, or other appropriate services at or prior to three (3) years of age, or when the child is no longer eligible for early intervention services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-35-1; filed Mar 11, 1999, 5:00 p.m.: 22 IR 2527; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-35-2 Providers eligible for reimbursement; certification

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

Sec. 2. Medicaid reimbursement is available for service coordination services provided to eligible children by either of the following, after he or she has been certified by and has successfully completed orientation to the First Steps Early Intervention system:

(1) Service coordinator specialist.
(2) Service coordinator associate.

(Office of the Secretary of Family and Social Services; 405 IAC 5-35-2; filed Mar 11, 1999, 5:00 p.m.: 22 IR 2528; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-35-3 Covered services

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

Sec. 3. The following are service coordination services that may be reimbursed by Medicaid:

(1) Development of the IFSP based on fifteen (15) minute increments of face-to-face contact of up to two and one-half (2½) hours per meeting and with a maximum time limit of seven and one-half (7½) hours annually, per eligible child.
(2) Ongoing service coordination services, based on a minimum of fifteen (15) minutes of contact, with a maximum of four (4) contacts per month, that consist of the following:
    (A) Assessment of the eligible child's needs.
    (B) Coordination and advocacy.
    (C) Monitoring the IFSP.
    (D) Evaluation of the IFSP.

Direct face-to-face service coordination with the family of the eligible child must occur and be documented at least four (4) times per year.

(Office of the Secretary of Family and Social Services; 405 IAC 5-35-3; filed Mar 11, 1999, 5:00 p.m.: 22 IR 2528; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-35-4 Prior authorization

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

Sec. 4. Service coordination services are exempt from prior authorization requirements. *(Office of the Secretary of Family and Social Services; 405 IAC 5-35-4; filed Mar 11, 1999, 5:00 p.m.: 22 IR 2528; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

Rule 36. Diabetes Self Management Training

405 IAC 5-36-1 DSMT policy; definitions

Authority: IC 12-8-6-5; 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 to, or enhance the patient's ability to, properly manage their diabetic condition, thereby optimizing their 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.

(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)*

405 IAC 5-36-2 Requirements for the provision of DSMT

Authority: IC 12-8-6-5; 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. 2. (a) DSMT must be medically necessary for the patient.

(b) DSMT must be ordered in writing by a physician or podiatrist licensed under applicable Indiana law.

(c) DSMT must be provided by a health care professional licensed under applicable Indiana law.

(d) The health care professional that provides DSMT must have specialized training in the management of diabetes. *(Office of the Secretary of Family and Social Services; 405 IAC 5-36-2; 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)*

405 IAC 5-36-3 Limitations on coverage of DSMT
Authority: IC 12-8-6-5; 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, 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)

Rule 37. Smoking Cessation Treatment Policy

405 IAC 5-37-1 Limitations
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 1. (a) Reimbursement is available for smoking cessation treatment subject to the requirements set forth in this rule and when provided in accordance with provider bulletins, provider manuals, and the provider agreement.

(b) Reimbursement is available for one (1) twelve (12) week course of smoking cessation treatment per recipient per calendar year.

(c) The twelve (12) week course of treatment may include prescription of any combination of smoking cessation products and counseling. One (1) or more modalities of treatment may be prescribed. Counseling must be included in any combination of treatment.

(d) Prior authorization is not required for smoking cessation products or counseling. *(Office of the Secretary of Family and Social Services; 405 IAC 5-37-1; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-37-2 Smoking cessation products
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 2. (a) Reimbursement is available to pharmacy providers for smoking cessation products when prescribed by a practitioner within the scope of his license under Indiana law.

(b) Products covered under this section include, but are not limited to, the following:

(1) Sustained release buproprion products.

(2) Nicotine replacement drug products (patch, gum, inhaler).

(Office of the Secretary of Family and Social Services; 405 IAC 5-37-2; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-37-3 Smoking cessation counseling
Authority: IC 12-8-6-5; 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 smoking cessation counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program and listed in subsection (b).

(b) The following may provide smoking cessation counseling services when prescribed by a practitioner within the scope of his 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.

(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)

Rule 38. Telemedicine Services

405 IAC 5-38-1 General provisions

Authority: IC 12-8-6-5; 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) Telemedicine services refer to a specific method of delivery of certain services, including medical exams and consultations, which are already reimbursed by Medicaid. Telemedicine uses videoconferencing equipment allowing a medical provider to render an exam or other service to a patient at distant location. Telemedicine services are covered by Medicaid within the parameters specified in this rule.

(b) Telemedicine is not the use of a:
(1) telephone transmitter for transtelephonic monitoring; or
(2) telephone or any other means of communication, consultation from one (1) doctor to another.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-1; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-38-2 Definitions

Authority: IC 12-8-6-5; 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. The following definitions apply throughout this rule:
(1) "Hub site" means the location of the physician or provider rendering consultation services.
(2) "Interactive television" or "IATV" means the videoconferencing equipment at the hub and spoke site that allows real time, face-to-face consultation.
(3) "Spoke site" means the location where the patient is physically located when services are provided.
(4) "Store and forward" means the electronic transmission of medical information for subsequent review by a health care provider at the hub site. Restrictions placed on store and forward reimbursement in this rule shall not disallow the permissible use of store and forward technology to facilitate reimbursable services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-2; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-38-3 Description of service

Authority: IC 12-8-6-5; 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. (a) In any telemedicine encounter, there will be the following:
(1) A hub site.
(2) A spoke site.
(3) An attendant to connect the patient to the specialist at the hub site.
(4) A computer or television monitor to allow the patient to have:
(A) real-time;

(B) interactive; and
(C) face-to-face;
communication with the hub specialist/consultant via IATV technology.
(b) Services may be rendered in an inpatient, outpatient, or office setting. *(Office of the Secretary of Family and Social Services; 405 IAC 5-38-3; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

405 IAC 5-38-4 Limitations
Authority: IC 12-8-6-5; 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. Telemedicine shall be limited by the following conditions:
(1) The patient must be:
(A) 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 only when the hub and spoke sites are greater than twenty (20) miles apart. Adequate documentation must be maintained as service is subject to postpayment review.
(4) 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.
(5) 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)

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