TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

ARTICLE 1. MEDICAID PROVIDERS AND SERVICES

NOTE: 405 IAC 1 was transferred from 470 IAC 5. Wherever in any promulgated text there appears a reference to 470 IAC 5, substitute 405 IAC 1. Refer to the note after each rule heading in this article for additional conversions.

Rule 1. General Provisions

NOTE: 405 IAC 1-1 was transferred from 470 IAC 5-1. Wherever in any promulgated text there appears a reference to 470 IAC 5-1, substitute 405 IAC 1-1.

405 IAC 1-1-1 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. (a) "Medical assistance" and "Medicaid" are used synonymously, and mean payment to or on behalf of part or all of the cost of medical or remedial services on behalf of eligible needy individuals as defined in IC 12-1-7-14.9 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*.

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

(c) "Provider" means an individual, state or local agency, corporate, or business entity which meets the requirements of 470 IAC 5-8-4.

(d) "Department" or "state department" means the state department of public welfare.

(e) "Contractor" means the entity which makes payment to Medicaid providers under a contract with the department pursuant to IC 12-1-7-17.1 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*.

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

(g) "Parameter" means the maximum amount and/or duration or a service within appropriate limits for which payment may be made without prior authorization or exception due to medical necessity or contra-indications.

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

(i) "Nursing home care" means in-patient care and services provided by nursing homes, also identified as long-term care facilities, licensed under Indiana law and certified as meeting Medicaid standards of care to provide one (1) of two (2) levels of care as described in 470 IAC 5-3 the Indiana's Medicaid Program Criteria for Level of Care by Long-Term Care Facilities, such levels of care being identified as skilled level of care and intermediate level of care.

(j) "Intermediate care for the mentally retarded" means care provided by an institution for the mentally retarded or a medical institution which institution or that portion thereof providing such care qualified as an intermediate care facility for the mentally retarded pursuant to the provisions of Title XIX of the Social Security Act.

(k) The pronoun "he" when used herein refers to the feminine as well as to the masculine gender. *(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-101; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 248; filed Sep 29, 1982, 3:19 pm: 5 IR 2321; filed Mar 14, 1986, 4:35 pm: 9 IR 1856; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-1) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

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

Authority: IC 12-13-5-1; IC 12-13-5-2; IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-1; IC 12-15-1-2; IC 12-15-1-3
Affected: IC 12-13-2-3; IC 12-13-7-3; IC 12-15-5-1; IC 12-15-12; IC 12-15-28-1

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

(b) In the event the office implements a managed care program, the recipient shall select a managed care provider who is responsible for coordinating the recipient's health care needs. If a recipient fails to select a managed care provider within a reasonable time after being furnished a list of managed care providers by the office, the office shall assign a managed care provider to the recipient. A Medicaid recipient may not receive services from a provider other than the designated managed care provider except in the following cases:

(1) Medical emergencies.

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

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

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

(c) In the event that the office determines that a Medicaid recipient has utilized any Medicaid coverage service or supply at a frequency or amount not medically reasonable or necessary, the office may restrict the benefits available to such Medicaid recipient for a period of time, not less than two (2) years nor more than five (5) years, sufficient in the opinion of the office, to prevent further abuses, by noting any restrictions on the face of the recipient's Medicaid card. The office may restrict the Medicaid recipient's benefits by:

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

(2) prohibiting the recipient from:

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

(B) receiving services from any specific provider(s) noted on the card.

(d) Any Medicaid recipient whose benefits have been restricted pursuant to subsection (c) may appeal such restriction. Recipient appeal rights shall be those provided for in 42 CFR as required by IC 12-15-28-1, and the notice and hearing will be in accordance with the requirements of 42 CFR 431.200 et seq. and 470 IAC 1-4.

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

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

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

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

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-102; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 249; filed Oct 7, 1982, 3:50 p.m.: 5 IR 2344; filed May 22, 1987, 12:45 p.m.: 10 IR 2280, eff Jul 1, 1987; filed Aug 22, 1994, 10:00 a.m.: 18 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-2) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

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

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) Filing of Claims for Reimbursement–All provider claims for payment for services rendered to recipients must be originally filed with the Medicaid contractor within twelve (12) months of the date of the provision of the service. A Medicaid provider who is dissatisfied with the amount of his reimbursement may appeal under the provisions of 470 IAC 1-4. However, prior to filing such an appeal, the provider must either:

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

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

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

(b) All requests for payment adjustments and/or reconsideration of a claim that has been denied must be submitted to the Medicaid contractor within sixty (60) days of the date of notification that the claim was paid or denied. In order to be considered for payment, each subsequent claim resubmission or adjustment request must be submitted within sixty (60) days of the most recent notification that the claim was paid or denied. The date of notification shall be considered to be three (3) days following the date

of mailing from the Medicaid contractor.

All claims filed after twelve (12) months of the date of the provision of the service, as well as claims filed after sixty (60) days of the date of notification that the claim was paid or denied shall be rejected for payment unless a waiver has been granted. In extenuating circumstances a waiver of the filing limit may be authorized by the contractor or SDPW when justification is provided to substantiate why the claim could not be filed or refiled within the filing limit.

Some examples of situations considered to be extenuating circumstances are:

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

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

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

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

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

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

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

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

In situations in which a patient receives a Medicaid covered service and then subsequently is determined to be eligible, retroactive to the date of service or before, a waiver of the filing limit, where necessary, may be granted if the provider bills Medicaid within one (1) year of the date of the retroactive eligibility determination.

In situations where a recipient receives a service outside Indiana by a provider who has not yet been enrolled or has not received a provider manual at the time services were rendered, the claims filing limitation may be waived, subject to approval by the SDPW. Such situations will be reviewed on an individual basis by the SDPW to ascertain if the provider made a good faith effort to enroll and submit claims in a timely manner.

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

(e) Payment Liability–Medicaid is only liable for the payment of claims filed by providers who were certified providers at the time the service was rendered and for services provided to persons who were enrolled in the Medicaid program as eligible recipients at the time service was provided. Payment may be made for services rendered during any one (1) or all of the three (3) months preceding the month of Medicaid application if the patient is found to be eligible during such period. As a correlation to this, non-certified providers giving the retroactive service must file a provider application retroactive to the beginning date of eligible service and meet provider certification requirements during the retroactive period.

A claim for services which requires prior authorization by the department provided during the retroactive period will not be paid unless such services have been reviewed and approved by the department prior to payment.

The claim will not be paid if the services provided are outside the service parameters as established by the department.

(f) Third Party Payment–(1) Resources from health insurance plans available to the recipient shall apply first to defraying the cost of medical services before any share of the Medicaid claim for payment is approved. Such resources shall include, but not be limited to, Medicare, Civilian Health and Medical Plan for Uniform Services (CHAMPUS), other health insurances, and Workman's Compensation. A provider of services to a recipient shall not submit a claim for reimbursement by Medicaid until he has first ascertained whether any such resource may be liable for all or part of the cost of the services and has sought reimbursement from that resource. With approval of the state department, a Medicaid claim may be paid prior to third party payment when the liability of the third party is yet to be determined through court proceedings, such as in paternity cases, or when the third party payment will not be available for an extended period of time, with recoupment by the department required when such third party resources become available.

(2) Third party payments applied to the recipient's cost of care shall be deducted from the total payment allowable from Medicaid, with Medicaid paying only the balance. Reimbursement rates are determined by the state department according to the requirements of federal and state laws governing rate setting for Medicaid services and shall be accepted as party payor.

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

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

(i) A Medicaid provider shall not collect from a Medicaid recipient or from the family of the Medicaid recipient any portion of his charge for a Medicaid covered service which is not reimbursed by the Indiana Medicaid program, except for copayment and any patient liability payment as authorized by law. (See 42 CFR 447.15.) *(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-103; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 250; filed Oct 7, 1982, 3:54 pm: 5 IR 2345; filed Mar 14, 1986, 4:35 pm: 9 IR 1857; filed Mar 15, 1988, 1:59 pm: 11 IR 2850; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-3) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-4 Denial of claim payment; basis; discretion of assistant secretary

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-21.5-3-7; IC 4-21.5-4; IC 12-15-13-3

Sec. 4. (a) The office of Medicaid policy and planning (office) may deny payment, or instruct the fiscal contractor to deny payment, to any provider for medical assistance services rendered, including materials furnished to any individual or claimed to be rendered or furnished to any individual, if, after investigation by the office, the office's designee, the Indiana Medicaid Fraud Control Unit (IMFCU), or other governmental authority, the office finds any of the following:

(1) The services claimed cannot be documented by the provider in accordance with 405 IAC 1-5-1.

(2) The claims were made for services or materials determined by licensed medical staff of the office, the office's designee, the IMFCU, or other governmental authority as not medically reasonable and necessary.

(3) The amount claimed for such services or materials has been or can be paid from other sources.

(4) The services claimed were provided to a person other than a person in whose name the claim is made.

(5) The services claimed were provided to a person who was not eligible for medical assistance at the time of the provision of the service.

(6) The claim for medical assistance services or materials arises out of any of the following acts or practices:

(A) Presenting, or causing to be presented, for payment any false or fraudulent claim for services or merchandise.

(B) Submitting, or causing to be submitted, information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(C) Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

(D) Failure to disclose, or make available to the office, or its authorized agent, records of services provided to Medicaid recipients and records of payments made therefor.

(E) Engaging in a course of conduct or performing an act deemed by the office to be improper or abusive of the Medicaid program or continuing such conduct following notification that the conduct should cease.

(F) Breach of the terms of the Medicaid Provider Certification Agreement or failure to comply with the terms of the Provider Certification on the Medicaid Claim Form.

(G) Overutilizing the Medicaid program by furnishing, or otherwise causing a recipient to receive, service(s) or merchandise not otherwise required or requested by the recipient.

(H) Violating any provision of state or federal Medicaid law or any rule or regulation promulgated pursuant thereto.

(I) Submission of a false or fraudulent application for provider status.

(J) Failure to meet standards required by the state of Indiana or federal law for participating in the Medicaid program.

(K) Charging a Medicaid recipient for covered services over and above that paid for by the office.

(L) Refusal to execute a new Provider Certification Agreement when requested by the office or its fiscal contractor to do so.

(M) Failure to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office.

(N) Failure to repay within sixty (60) days or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments, except as provided in IC 12-15-13-3.

(O) Presenting claims for which federal financial participation is not available.

(7) The claim arises out of any act or practice prohibited by rules and regulations of the office.

(8) The provider, any person with an ownership or control interest in the provider entity, or a managing employee is convicted of a criminal offense related to the provision of medical assistance services or submission of claims for payment for such services.

(b) The decision as to denial of payment for a particular claim or claims is at the discretion of the assistant secretary of the office or his duly authorized representative. This decision shall be final and:

(1) will be mailed to the provider by United States mail at the address contained in the office records and on the claims or transmitted electronically if the provider has elected to receive electronic remittance advices;

(2) will be effective upon receipt; and

(3) may be administratively appealed under section 3 of this rule.

(c) The decision as to claim payment suspension is at the discretion of the assistant secretary of the office, or his duly authorized representative, and may include any of the following:

(1) The denial of payment for all claims that have been submitted by the provider pending further investigation by the office, the office's designee, the IMFCU, or other governmental authority.

(2) The suspension or withholding of payment on any or all claims of the provider pending an audit or further investigation by the office, the office's designee, the IMFCU, or other governmental authority.

(d) The decision of the assistant secretary or his duly authorized representative under subsection (c) shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) contain a brief description of the decision;

(3) become final fifteen (15) days after its receipt; and

(4) contain a statement that any appeal from the decision shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 1-1.5-2.

(e) If an emergency exists, as determined by the office, the assistant secretary or his duly authorized representative may issue an emergency directive suspending or withholding payment on any or all claims of the provider pending further investigation by the office, the office's designee, the IMFCU, or other governmental authority under IC 4-21.5-4. Any order issued under this subsection shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) become effective upon receipt;

(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and

(4) contain a statement that any appeal from the decision of the assistant secretary made under this subsection shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 1-1.5-2.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-103.1; filed Jun 19, 1979, 2:16 p.m.: 2 IR 1123; filed Sep 29, 1982, 3:14 p.m.: 5 IR 2346; filed Dec 22, 1995, 2:15 p.m.: 19 IR 1074; errata filed Feb 12, 1996, 10:45 a.m.: 19 IR 1373; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3369; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-3.5) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-4) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-1-5 Overpayments made to providers; recovery

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

Affected: IC 4-6-10; IC 4-21.5-3; IC 12-15-1; IC 12-15-6-5; IC 12-15-13-3; IC 12-15-23-2; IC 16-21

Sec. 5. (a) Under IC 12-15-21-3(5) and IC 12-15-21-3(7), the office of Medicaid policy and planning (office) may recover payment, or instruct the fiscal contractor to recover payment, from any Medicaid provider for services rendered to an individual, or claimed to be rendered to an individual, if the office, after investigation or audit, finds that:

(1) the services paid for cannot be documented by the provider as required by 405 IAC 1-5-1;

(2) the amount paid for such services has been or can be paid from other sources;

(3) the services were provided to a person other than the person in whose name the claim was made and paid;

(4) the service reimbursed was provided to a person who was not eligible for medical assistance at the time of the provision of the service;

(5) the paid claim arises out of any act or practice prohibited by law or by rules of the office;

(6) overpayment resulted from an inaccurate description of services or an inaccurate usage of procedure codes;

(7) overpayment resulted from the provider's itemization of services rather than submission of one (1) billing for a related

group of services provided to a recipient (global billing) as set out in the office's medical policy;

(8) overpayment resulted from duplicate billing;

(9) overpayment resulted from claims for services or materials determined to have been not medically reasonable or necessary; or

(10) overpayment to the provider resulted from any other reason not specified in this subsection.

(b) Under IC 12-15-21-3(5), the office may determine the amount of overcharges made by a Medicaid provider by means of a random sample audit. The random sample audit shall be conducted in accordance with generally accepted statistical methods, and the selection criteria shall be based on a table of random numbers derived from any book of random sampling generally accepted by the statistical profession.

(c) The office or its designee may conduct random sample audits for the purpose of determining overcharges to the Indiana Medicaid program. The following criteria apply to random sample audits:

(1) In the event that the provider wishes to appeal the accuracy of the random sample methodology under IC 4-21.5-3, the provider may present evidence to show that the sample used by the office was invalid and therefore cannot be used to project the overpayments identified in the sample to total billings for the audit period.

(2) The provider may also conduct an audit, at the provider's expense, of either a valid random sample audit, using the same random sampling methodology as used by the office, or an audit of one hundred percent (100%) of medical records of payments received during the audit period. Any such audit must be completed within one hundred eighty (180) days of the date of appeal and must demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with state and federal law. The provider must submit supporting documentation to demonstrate this compliance.

(d) If the office determines that an overcharge has occurred, the office shall notify the provider by certified mail. The notice shall include a demand that the provider reimburse the office, within sixty (60) days of the provider's receipt of the notification, for any overcharges determined by the office. Except as provided in subsection (f), a provider who receives a notice and request for repayment may elect to do one (1) of the following:

(1) Repay the amount of the overpayment not later than sixty (60) days after receiving notice from the office, including interest from the date of overpayment.

(2) Request a hearing and repay the amount of the alleged overpayment not later than sixty (60) days after receiving notice from the office.

(3) Request a hearing not later than sixty (60) days after receiving notice from the office and not repay the alleged overpayment, except as provided in subsection (e).

(e) If:

(1) a provider elects to proceed under subsection (d)(3); and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider owes the money;

the provider shall pay the amount of the overpayment, including interest from the date of the overpayment.

(f) A hospital licensed under IC 16-21 that receives a notice and request for repayment under subsection (d) has one hundred eighty (180) days to elect one (1) of the actions under subsection (d)(1), (d)(2), or (d)(3).

(g) Under IC 12-15-23-2, the office may enter into an agreement with the provider regarding the repayment of any overpayment made to the provider. Such agreement shall state that the amount of overpayment shall be deducted from subsequent payments to the provider. Such subsequent payment deduction shall not exceed a period of six (6) months from the date of the agreement. The repayment agreement shall include provisions for the collection of interest on the amount of the overpayment. Such interest shall not exceed the percentage as set out in IC 12-15-13-3(f)(1).

(h) Whenever the office determines, after an investigation or audit, that an overpayment to a provider should be recovered, the office shall assess an interest charge in addition to the amount of overpayment demanded. Such interest charge shall not exceed the percentage set out in IC 12-15-13-3(f)(1). Such interest charge shall be applied to the total amount of the overpayment, less any subsequent repayments. Under IC 12-15-21-3(6), the interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists. When an overpayment is determined pursuant to the results of a random sample audit, the date the overpayment occurred shall be considered to be the last day of the audit period, and interest will be calculated from the last day of the audit period.

(i) If the office recovers an overpayment to a provider that is subsequently found not to have been owing to the office, either in whole or in part, then the office will pay to the provider interest on the amount erroneously recovered from the provider. Such interest will accrue from the date that the overpayment was recovered by the office until the date the overpayment is restored to the

provider. Such interest will accrue at the rate of interest set out in IC 12-15-13-3(f)(2). Also, for hospitals that receive a notice that the provider has been underpaid by the office as a result of the cost settlement process, the office will pay interest to the hospital on the amount of the underpayment, consistent with 405 IAC 1-1.5-5(c). The office will not pay interest to a provider under any other circumstances except under the condition described in this subsection.

(j) If, after receiving a notice and request for repayment:

(1) the provider fails to elect one (1) of the options listed in subsection (d) within sixty (60) days; or

(2) a hospital licensed under IC 16-21 fails to elect one (1) of the options listed in subsection (d) within one hundred eighty (180) days;

and the administrator determines that reasonable grounds exist to suspect that the provider has acted in a fraudulent manner, then the administrator shall immediately certify the facts of the case to the Indiana Medicaid Fraud Control Unit established under IC 4-6-10.

(k) If, at any time after the discovery of the overpayment, the administrator determines that reasonable grounds exist to suspect that the provider has acted in a fraudulent manner, the administrator shall immediately certify the facts of the case to the Indiana Medicaid Fraud Control Unit established under IC 4-6-10.

(l) Nothing in this section shall be construed to preclude the office from revising a provider's rate of reimbursement under 405 IAC 1-12 or 405 IAC 1-14.1 *[405 IAC 1-14.1 was repealed filed May 30, 1997, 4:25 p.m.: 20 IR 2774.]* as a result of an audit. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1-5; filed Sep 23, 1982, 10:05 a.m.: 5 IR 2347; filed Mar 14, 1986, 4:35 p.m.: 9 IR 1859; filed May 22, 1987, 12:45 p.m.: 10 IR 2281, eff Jul 1, 1987; filed Jul 29, 1992, 10:00 a.m.: 15 IR 2567; filed Apr 4, 1995, 10:45 a.m.: 18 IR 2024; errata filed May 17, 1995, 8:10 a.m.: 18 IR 2415; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3371; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-3.6) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-5) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-5.1 Provider payments during pendency of appeals; recovery

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

Sec. 5.1. (a) The office of Medicaid policy and planning (office) may recover payment, or instruct the fiscal contractor to recover payment, from any Medicaid provider listed in subsection (c) for services rendered to an individual if such services are determined to have been not medically necessary or not reasonable or otherwise inappropriate. Recovery of payments may be made:

(1) when the office is required by 42 CFR 431.230(a) to maintain services to a recipient during the pendency of an appeal, and the hearing decision is favorable to the office; or

(2) when the office has been required, under 42 CFR 431.246, to make corrective payments following an evidentiary hearing decision favorable to the appellant, and the secretary or the secretary's designee thereafter renders a decision favorable to the office at administrative review.

(b) The office may recoup under subsection (a) when the appeal has been voluntarily dismissed by the appellant.

(c) Services for which the office, or its fiscal contractor, may recover payment under subsection (a) are limited to those rendered by any of the following providers:

(1) Inpatient hospital facilities.

(2) Nursing facilities.

(3) Community residential facilities.

(4) Intermediate care facilities for the mentally retarded.

(d) Interest shall be assessed on amounts recouped under this section and shall accrue from the date of the overpayment. Such interest charge shall be determined under IC 12-15-13-3(f)(1). *(Office of the Secretary of Family and Social Services; 405 IAC 1-1-5.1; filed Dec 19, 1995, 2:50 p.m.: 19 IR 1081; errata filed Feb 12, 1996, 10:45 a.m.: 19 IR 1568; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-1-6 Sanctions against providers; determination after investigation

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7; IC 4-21.5-4; IC 12-15-13-3

Sec. 6. (a) If, after investigation by the office of Medicaid policy and planning (office), the office's designee, the Indiana Medicaid Fraud Control Unit (IMFCU), or other governmental authority, the office determines that a provider has violated any provision of IC 12-15, or has violated any rule established under one (1) of those sections, the office may impose one (1) or more of the following sanctions:

(1) Deny payment to the provider for medical assistance services rendered during a specified period of time.

(2) Reject a prospective provider's application for participation in the medical assistance program.

(3) Remove a provider's certification for participation in the medical assistance program (decertify the provider).

(4) Assess a fine against the provider in an amount not to exceed three (3) times the amounts paid to the provider in excess of the amounts that were legally due.

(5) Assess an interest charge, at a rate not to exceed the rate established by IC 12-15-13-3(f)(1), on the amounts paid to the provider in excess of the amounts that were legally due. The interest charge shall accrue from the date of the overpayment to the provider.

(b) Specifically, the office may impose the sanctions in subsection (a) if, after investigation by the office, the office's designee, the IMFCU, or other governmental authority, the office determines that the provider:

(1) submitted, or caused to be submitted, claims for medical assistance services which cannot be documented by the provider;

(2) submitted, or caused to be submitted, claims for medical assistance services provided to a person other than a person in whose name the claim is made;

(3) submitted, or caused to be submitted, any false or fraudulent claims for medical assistance services or merchandise;

(4) submitted, or caused to be submitted, information with the intent of obtaining greater compensation than that which the provider is legally entitled (including charges in excess of the fee schedule or usual and customary charges);

(5) submitted, or caused to be submitted, false information for the purpose of meeting prior authorization requirements;

(6) engaged in a course of conduct or performed an act deemed by the office to be abusive of the Medicaid program or continuing such conduct following notification that the conduct should cease;

(7) breached, or caused to be breached, the terms of the Medicaid provider certification agreement;

(8) failed to comply with the terms of the provider certification on the Medicaid claim form;

(9) overutilized, or caused to be overutilized, the Medicaid program;

(10) submitted, or caused to be submitted, a false or fraudulent provider certification agreement;

(11) submitted, or caused to be submitted, claims for medical assistance services for which federal financial participation is not available;

(12) submitted, or caused to be submitted, any claims for medical assistance services or merchandise arising out of any act or practice prohibited by the criminal provisions of the Indiana Code or by the rules of the office;

(13) failed to disclose or make available to the office, the office's designee, the IMFCU, or other governmental authority, after reasonable request and notice to do so, documentation of services provided to Medicaid recipients and Medicaid records of payments made therefor;

(14) failed to meet standards required by the state of Indiana or federal law for participation;

(15) charged a Medicaid recipient for covered services over and above that paid for by the office;

(16) refused to execute a new provider certification agreement when requested to do so;

(17) failed to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office;

(18) failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments, unless an appeal is pending and the provider has elected not to repay an alleged overpayment pursuant to section 5(d)(3) of this rule; or

(19) billed the Medicaid program more than the usual and customary charge to the provider's private pay customers.

(c) The assistant secretary of the office or his duly authorized representative may enter a directive imposing a sanction under IC 4-21.5-3-6. Any directive issued under this subsection shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) contain a brief description of the order;

(3) become final fifteen (15) days after its receipt; and

(4) contain a statement that any appeal from the decision of the assistant secretary made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 1-1.5-2.

(d) If an emergency exists, as determined by the office, the assistant secretary or his duly authorized representative may issue an emergency directive imposing a sanction under IC 4-21.5-4. Any order issued under this subsection shall:

(1) be served upon the provider by certified mail, return receipt requested;
(2) become effective upon receipt;
(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and
(4) contain a statement that any appeal from the decision of the assistant secretary made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 1-1.5-2.
(e) The decision to impose a sanction shall be made at the discretion of the assistant secretary or his authorized representative.
(f) Prepayment review of claims is not a sanction and is not subject to appeal. *(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-105; filed Jun 19, 1979, 2:16 p.m.: 2 IR 1124; filed Sep 23, 1982, 9:59 a.m.: 5 IR 2349; filed Dec 22, 1995, 2:15 p.m.: 19 IR 1076; errata, 19 IR 1373; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3372; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-4.5) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-6) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-7 Nursing home rate setting; governing provisions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-22-2; IC 12-13-7-3; IC 12-15

Sec. 7. Nursing Home Rate Setting. In accordance with the provisions of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*; IC 4-22-2 as amended by Indiana Public Law 38, Acts of 1977; and in conformity with the provisions of Title XIX of the federal Social Security Act and related federal regulations, the state board of public welfare hereby promulgates sections 100 through 1600 inclusive of a document issued by the department in July, 1976 as amended in August 1977 entitled Indiana Department of Public Welfare, Rate Setting Criteria for Nursing Homes, Medicaid Program, Skilled Nursing Facilities and Intermediate Care Facilities.

If any provision of the above cited document is or shall become inconsistent with any other regulation promulgated by the state board of public welfare the provision of this regulation shall govern. If the content of the above cited document is inconsistent with any subsequently enacted amendment of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the federal Social Security Act or any regulation promulgated thereunder, the amendment to IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the Social Security Act or the regulation promulgated thereunder, shall govern until such time as the above cited document can be amended.

If any part of the Indiana Department of Public Welfare, Rate Setting Criteria for Nursing Homes, Medicaid Program, Skilled Nursing Facilities and Intermediate Care Facilities document or the application of it to any person or circumstance is held invalid, and invalidity does not affect other provisions or applications of the document which can be given effect without invalid provisions or application, and to this end this document is severable.

IC 4-22-2
IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-106; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 252; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-5) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-7) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-8 Level of care criteria for long-term care facilities; governing provisions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-22-2; IC 12-13-7-3; IC 12-15

Sec. 8. Level of Care Criteria for Long-Term Care Facilities. In accordance with the provisions of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*; IC 4-22-2 as amended by Indiana Public Law 38, Acts of 1977; and in conformity with the provisions of Title XIX of the federal Social Security Act and related federal regulations, the state board of public welfare hereby promulgates a document issued by the department on January 5, 1976 as amended in May, 1977, entitled Indiana's Medicaid Program Criteria for Level of Care Provided by Long-Term Care Facilities *[405 IAC 1-3]*.

If any provision of the above cited document *[405 IAC 1-3]* is or shall become inconsistent with any other regulation promulgated by the state board of public welfare the provision of this regulation *[405 IAC 1-3]* shall govern. If the content of the

above cited document *[405 IAC 1-3]* is inconsistent with any subsequently enacted amendment of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the federal Social Security Act or any regulation promulgated thereunder, the amendment to IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the Social Security Act or the regulation promulgated thereunder shall govern until such time as the above cited document *[405 IAC 1-3]* can be amended.

If any part of the Indiana's Medicaid Program Criteria for Level of Care Provided by Long-Term Care Facilities document *[405 IAC 1-3]* or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the document which can be given effect without the invalid provision or application, and to this end this document is severable.

IC 4-22-2

IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-107; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 253; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-6) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-8) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-9 Nursing home admission; governing provisions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-22-2; IC 12-13-7-3; IC 12-15

Sec. 9. Nursing Home Admission. In accordance with the provisions of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*; IC 4-22-2 as amended by Indiana Public Law 38, Acts of 1977; and in conformity with the provisions of Title XIX of the federal Social Security Act and related federal regulations, the state board of public welfare hereby promulgates a document issued on June 1, 1976 and amended October 12, 1976 by the department entitled Medicaid DPW Bulletin No. 3.

If any provision of the above cited document is or shall become inconsistent with any other regulation promulgated by the state board of public welfare the provision of this regulation shall govern. If the content of the above cited document is inconsistent with any subsequently enacted amendment of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the federal Social Security Act or any regulation promulgated thereunder, the amendment to IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the Social Security Act or the regulation promulgated thereunder shall govern until such time as the above cited document can be amended.

If any part of the document Medicaid DPW Bulletin No. 3, as amended, or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications which can be given effect without the invalid provision or application, and to this end this document is severable.

IC 4-22-2

IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-108; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 253; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-7) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-9) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-10 Intermediate care for the mentally retarded; governing provisions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-22-2; IC 12-13-7-3; IC 12-15

Sec. 10. Intermediate Care for the Mentally Retarded (ICF/MR). In accordance with provisions of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*; IC 4-22-2 as amended by Indiana Public Law 38, Acts of 1977; and in conformity with the provisions of Title XIX of the federal Social Security Act and related federal regulations, the state board of public welfare hereby promulgates a document issued on August 15, 1977 by the department entitled Medicaid

Bulletin–Intermediate Care for the Mentally Retarded (ICF/MR) *[405 IAC 1-1-9]*.

If any provision of the above cited document *[405 IAC 1-1-9]* is or shall become inconsistent with any other regulation promulgated by the state board of public welfare, the provision of this regulation *[405 IAC 1-1-9]* shall govern. If the content of the above document is inconsistent with any subsequently enacted amendment of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the federal Social Security Act or any regulation promulgated thereunder, the amendment to IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the Social Security Act or the regulation promulgated thereunder shall govern until such time as the above cited document *[405 IAC 1-1-9]* can be amended.

If any part of the document *[405 IAC 1-1-9]* cited above or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications which can be given effect without the invalid provision or application, and to this end this document is severable.

IC 4-22-2

IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-109; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 254; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-8) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-10) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-11 Intermediate care for the mentally retarded; eligibility

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. Intermediate Care for the Mentally Retarded (ICF/MR) is to be provided for persons in an institution which meets the Federal certification standards to participate as an eligible Medicaid provider. Intermediate care services are designed for persons who are mentally retarded or with certain other conditions as specified herein. The services and/or treatment programs are delivered on an in-patient basis and under the direction and supervision of the required professional staff. Admissions to Intermediate Care Facilities for the Mentally Retarded must be based upon a determination of the need for such care by an interdisciplinary professional team. Approval by the State Department of Public Welfare–Medicaid Division, must be received by the ICF/MR institution prior to admission, or in cases of those individuals who make application while in the institution, prior to payment for that service. Intermediate Care for the Mentally Retarded (ICF/MR) will be provided by the Medicaid program, for eligible persons who must meet these two conditions:

(1) Patient or resident has a diagnosis of mental retardation or related conditions of epilepsy, cerebral palsy, or other developmental disability found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals.

(a) Patient or resident may be severely or profoundly retarded, moderately retarded, severely physically handicapped, aggressive, assaultive, security risk, or manifesting severe hyperactive or psychotic-like behavior.

(b) Patient or resident may be moderately retarded and may require habit training, training and guidance in the activities of daily living, and development of self-help skills for maximum independence and as needed by the patient or resident.

(c) Patient or resident may be in vocational training programs or adults who work in sheltered workshops.

(2) Patient or resident must have a comprehensive evaluation covering physical, emotional, social and cognitive factors conducted by an interdisciplinary professional team.

In addition to the above required conditions, eligible persons may require any of the following professional services:

(1) Patient or resident may require professional medical supervision for the administration of medicines and/or treatments.
(2) Physician services.
(3) Dental services.
(4) Nursing services.
(5) Pharmacy services.
(6) Training and habilitation.
(7) Modified or special diets to meet nutritional needs.
(8) Physical therapy services.

(9) Speech pathology and audiological services.
(10) Occupational therapy services.
(11) Recreational therapy services.
(12) Psychological services.
(13) Social services.

(Office of the Secretary of Family and Social Services; Intermediate Care For The Mentally Retarded; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 284; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-9) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-11) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-1-12 Regular access authority to medicaid division personal information system

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

Sec. 12. Regular Access Authority to the Indiana State Department of Public Welfare Medicaid Division Personal Information System. The following individuals have regular access authority to the information contained in the personal information systems maintained by the Medicaid Division of the Indiana State Department of Public Welfare, subject to the confidentiality requirements in State Department of Public Welfare Regulation 1-201 *[470 IAC 1-3-1]*.

(1) Employees of the Indiana State Department of Public Welfare.

(2) Employees of the County Welfare Departments of the State of Indiana.

(3) Employees of other agencies of the State of Indiana which have been given the responsibility of administering any part of the programs set forth in State Department of Public Welfare Regulation 1-201 *[470 IAC 1-3-1]*.

(4) All officials and their staffs who are charged by law with the responsibility of pursuing criminal and/or civil prosecution.

(5) Employees of the fiscal agent who has entered into a contract with the State of Indiana pursuant to IC 12-1-7-17 *[Repealed by P.L.80-1984, SECTION 10.]*.

(6) Any other individual, agency or official whose duties are directly connected with the administration of a plan or program approved under Title XIX of the federal Social Security Act, or any other federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need.

IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 4-1-6-2
IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.]*
IC 12-1-7-28 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-130; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 254; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-10) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-12) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-13 Subrogation of claims

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. Subrogation. The Indiana State Department of Public Welfare shall be subrogated to all claims by Medicaid recipients against third parties to the extent of Medicaid benefits received by the recipients, when the direct or proximate cause of the necessity to pay such benefits is the negligence or other legal liability of such third parties.

IC 12-1-7-16 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.] (Office of the Secretary of Family and Social Services; 5-198; filed Mar 28, 1978, 8:55 am: Rules and Regs. 1979, p. 320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-11) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-13) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

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

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. Severability. If any provision in Indiana State Department of Public Welfare Regulations 5-101 *[405 IAC 1-1-1]* et seq. is or shall become inconsistent with any subsequently enacted amendment to the federal Social Security Act or any regulation promulgated thereunder, the amendment to the Social Security Act or the regulation promulgated thereunder shall govern until such time as the Indiana State Department of Public Welfare Regulations can be amended.

If any part of Indiana State Department of Public Welfare Regulations 5-101 *[405 IAC 1-1-1]* et seq. or the application of them to any person, entity or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Regulations which can be given effect without the invalid provision or application, and to this end Indiana State Department of Public Welfare Regulations 5-101 *[405 IAC 1-1-1]* et seq. are severable.

IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-199; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 255; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-12) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-14) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-15 Third party liability; 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. 15. (a) The following definitions are intended to apply only to 470 IAC 5-1-13:

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

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

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

(B) the signature of an authorized Medicaid employee.

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

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

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

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

(1) payment from a third party was not immediately available;

(2) there are disputes and delays in the coordination of benefits;

(3) the third party was not identified;

(4) the department erroneously made payment before the third party or all other parties had made payment;

(5) a court order has been issued; or

(6) the recipient asserts a claim against a third party who is or may be liable for the injury, illness, or disease of a Medicaid applicant or recipient.

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

(1) the recipient has not done so; and

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

(d) In perfecting its lien, the department shall take the following action before the third party makes final settlement to the

Medicaid recipient as total compensation for the recipient's injury, illness, or disease:

(1) serve notice:

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

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

(2) file a claim which:

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

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

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

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

(E) is certified by an authorized Medicaid employee.

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

(1) filing a written notice in the Marion County Circuit Court stating:

(A) the name and address of the recipient;

(B) that the individual is eligible for medical assistance;

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

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

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

(A) the recipient;

(B) the recipient's attorney; and

(C) the insurer or other third parties.

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

(1) on state letterhead; and

(2) sent by certified mail.

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

(A) name of employer;

(B) name of policyholder;

(C) employee identification number; and

(D) claim certificate number.

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

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

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

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

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

(i) Once the Medicaid program has been reimbursed for the department's claim by the insurer, the insurer has discharged its responsibility for that claim. Neither the insurer nor the recipient shall be held liable for any remaining balance. For any provider seeking adjustments in payment, recourse is limited to an administrative appeal as provided by 470 IAC 1-4.

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

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

(l) The department may waive its lien, at its discretion. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1-15; filed Sep 29, 1982, 3:09 pm: 5 IR 2322; filed May 22, 1987, 12:45 pm: 10 IR 2282, eff Jul 1, 1987; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-13) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-15) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-16 Insurance information; release

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 12-15-29

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

(1) is doing business in this State; and

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

(b) In accordance with IC 12-1-7-24.1 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*, a Medicaid applicant or recipient or one legally authorized to seek Medicaid benefits on behalf of the applicant or recipient shall be considered to have authorized all insurers to release to the department all available information needed by the department to secure or enforce its rights pertaining to third party liability collection.

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

(1) name, address, and social security number of the insured;

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

(3) names of covered dependents whom the State certifies are applicants or recipients;

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

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

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

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

(8) any additional co-insurance information which may be on file;

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

(10) copies of checks and their endorsements when these documents are needed as part of an investigation of a recipient and/or provider; and

(11) other policy information which the department certifies in writing is necessary to secure and enforce its rights pertaining to third party liability collection;

(12) carrier information, including:

(A) name and address of carrier;

(B) adjustor's name and address; and

(C) policy number and/or claim number;

(13) claims information, including:

(A) identity of the individual to whom the service was rendered;

(B) identity of the provider rendering services;

(C) identity and position of provider's employee rendering said services, if necessary for claims processing;

(D) date on which said services were rendered; and

(E) a detailed explanation of charges and benefits.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1-16; filed Sep 29, 1982, 3:21 pm: 5 IR 2320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-14) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-16) by P.L.9-1991, SECTION 131, effective January 1, 1992.

Rule 1.5. Provider Reimbursement Appeal Procedures

405 IAC 1-1.5-1 Scope

Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 1. (a) This rule governs the procedures for appeals to the office of Medicaid policy and planning (office) involving actions or determinations of reimbursement for all Medicaid providers.

(b) This rule governs the procedures for appeals to the office from the following actions or determinations:

(1) Setting rates of reimbursement.

(2) Any action based upon a final audit.

(3) Determination of change of provider status for purposes of setting a rate of reimbursement.

(4) Determination by the office that an overpayment to a provider has been made due to a year-end cost settlement.

(5) Any other determination by the office that a provider has been paid more than it was entitled to receive under any federal or state statute or regulation.

(6) The office's refusal to enter into a provider agreement.

(7) The office's suspension, termination, or refusal to renew an existing provider agreement.

(c) Notwithstanding subsections (a) and (b), this rule does not govern determinations by the office or its contractor with respect to the authorization or approval of Medicaid services requested by a provider on behalf of a recipient. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-1; filed Oct 31, 1994, 3:30 p.m.: 18 IR 862; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-1.5-2 Appeal requests

Authority: IC 12-15-21
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7; IC 12-8-6-6; IC 12-15-13-3

Sec. 2. (a) Appeals governed by this rule will be held in accordance with IC 4-21.5-3, except as specifically set out in this rule. The ultimate authority for purposes of this section is the secretary of family and social services administration, in accordance with IC 12-8-6-6.

(b) A request for an appeal must be filed within the following time limits:

(1) A request for an appeal of a determination that an overpayment has occurred must be filed within the time limits set out in IC 12-15-13-3.

(2) A hospital's request for an appeal of an action described in IC 4-21.5-3-6(a)(3) and IC 4-21.5-3-6(a)(4) must be filed within one hundred eighty (180) days.

(3) All other appeal requests governed by this rule must be filed with the ultimate authority within fifteen (15) calendar days of receipt of the determination by the office of Medicaid policy and planning (office), in accordance with IC 4-21.5-3-7. However, any provider subject to administrative review or reconsideration under this article must seek administrative review or reconsideration prior to filing an appeal request.

(c) An appeal request must state facts demonstrating that:

(1) the petitioner is a person to whom the order is specifically directed;

(2) the petitioner is aggrieved or adversely affected by the order; or

(3) the petitioner is entitled to review under any law.

Failure of the provider to file the appeal request within the time limits listed in subsection (b) will result in the waiver of any right to appeal from the office's determination.

(d) The provider must file with the office a statement of issues:

(1) within forty-five (45) calendar days after the provider receives notice of the determination of the office; or

(2) at the time the provider files a timely request for appeal;

whichever is later.

(e) The statement of issues shall set out in detail:

(1) the specific findings, action, or determinations of the office from which the provider is appealing;

(2) with respect to each finding, action, or determination, why the provider believes that the office's determination was in error; and

(3) with respect to each finding, action, or determination, all statutes or rules supporting the provider's contentions of error.

(f) A hospital appealing an action described in IC 4-21.5-3-6(a)(3) and IC 4-21.5-3-6(a)(4) must include its statement of issues in its petition for review.

(g) The statement of issues shall govern the scope of the issues to be adjudicated in the appeal under this rule. The provider will not be permitted to expand the appeal beyond the statement of issues with respect to:

(1) the specific findings, action, or determination of the office; or

(2) the reason or rationale supporting the provider's appeal.

(h) The provider may supplement or modify its statement of issues for good cause shown, up to sixty (60) calendar days after the appeal request is mailed to the office. The administrative law judge assigned to hear the appeal will determine good cause.

(i) Within thirty (30) days after filing a petition for review, and upon a finding of good cause by the administrative law judge, a hospital appealing an action described in IC 4-21.5-3-6(a)(3) and IC 4-21.5-3-6(a)(4) may amend the statement of issues contained in a petition for review to add one (1) or more additional issues.

(j) Failure of the provider to timely file a statement of issues within forty-five (45) calendar days from the date the provider files the appeal request will result in automatic certification to the secretary for summary review, in accordance with section 3 of this rule.

(k) Notwithstanding subsections (d) through (g), a hospital provider that files an appeal after a determination regarding year-end cost settlement may preserve any Medicaid issues that are affected by any Medicare appeal issues, by indicating in its statement of issues that Medicare issues timely filed before the fiscal intermediary are also preserved in its Medicaid statement of issues. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-2; filed Oct 31, 1994, 3:30 p.m.: 18 IR 862; errata filed Feb 28, 1995, 2:30 p.m.: 18 IR 1836; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3374; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-1.5-3 Summary review

Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 3. (a) The office of Medicaid policy and planning (office) will provide a summary review by the secretary of family and social services administration (secretary) of certain issues set out in the provider's statement of issues. Issues in the provider's statement of issues that challenge the propriety of:

(1) all or part of the general methodology or criteria utilized by the office for setting rates;

(2) all or part of the general methodology or criteria utilized by the office with respect to any audits;

(3) all or part of the general methodology or criteria utilized by the office for making determinations with respect to change of provider status; and

(4) all or part of any other general methodology or criteria utilized by the office for making any determination set out in section 1(b) of this rule;

will be certified for summary review by the secretary.

(b) The office shall not certify for summary review any issue in which the provider challenges the application of the office's methodology or criteria in the provider's particular circumstances. Issues involving application of the office's methodology or criteria will be set for an evidentiary hearing under IC 4-21.5-3. The administrative law judge shall exclude any:

(1) evidence or argumentation on issues certified to the secretary; or

(2) issues not specifically enumerated in the provider's statement or amended statement of issues.

(c) For appeals filed before the effective date of this rule, the office may certify issues determined under subsection (a) to the secretary or the secretary's designee, according to the issues set out in the provider's appeal letter.

(d) There shall be no appeal from a determination by the office certifying any issues for summary review by the secretary. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-3; filed Oct 31, 1994, 3:30 p.m.: 18 IR 863; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-1.5-4 Decision on summary review

Authority: IC 12-15-21
Affected: IC 4-21.5-3-28

Sec. 4. (a) Upon a determination of the office of Medicaid policy and planning (office) that any or all of the issues in the

provider's statement of issues concern issues in section 3(a) of this rule, the office will certify to the secretary of family and social services administration (secretary) those issues for summary review by the secretary or the secretary's designee. With respect to each issue certified by the office, the secretary or the secretary's designee will issue a decision:

(1) affirming the determination of the office;

(2) dissolving the determination of the office; or

(3) remanding the determination of the office for an evidentiary hearing before an administrative law judge.

(b) The decision of the secretary or the secretary's designee on summary review shall be rendered within forty-five (45) calendar days after certification by the office to the secretary.

(c) The secretary shall send a notice of the decision on summary review to the provider. The decision on summary review of the secretary or the secretary's designee is interlocutory unless it adjudicates all the issues in the provider's appeal. It is not a final order until all issues in the provider's statement of issues are adjudicated by the secretary or the secretary's designee under IC 4-21.5-3-28. A provider may not seek judicial review of an adverse determination of the secretary on summary review until such time as a final order on all the issues in the provider's statement of issues is rendered. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-4; filed Oct 31, 1994, 3:30 p.m.: 18 IR 864; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-1.5-5 Repayment of overpayment to office

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

Sec. 5. (a) The office of Medicaid policy and planning (office) may require the repayment of any amount determined by the office to have been paid to the provider in error, prior to an evidentiary hearing or summary review, unless an appeal is pending and the provider has elected not to repay an alleged overpayment pursuant to 405 IAC 1-1-5(d)(3). The office may, in its discretion, recoup any overpayment to the provider by the following means:

(1) Offset the amount of the overpayment against current Medicaid payments to a provider.

(2) In the case of an institutional provider, offset the amount of the overpayment to any or all of the Medicaid facilities owned by the provider until the overpayment has been satisfied.

(3) Require that the provider satisfy the overpayment by refunding the entire amount of the overpayment to the office directly.

(4) Enter into an agreement with the provider in accordance with 405 IAC 1-1-5.

(b) Interest from the date of the overpayment will be assessed even if the provider repays the overpayment to the office within thirty (30) days after receipt of the notice of the overpayment. This subsection applies to any of the methods of recoupment set out in this section. Interest on overpayments shall not exceed the percentage set out in IC 12-15-13-3(f)(1).

(c) Notwithstanding any other rule in this article, for hospitals who receive a notice that the provider has been underpaid by the office as a result of the cost settlement process, the office will pay interest to the hospital on the amount of the underpayment. Such interest will accrue from the date of the underpayment at the rate of interest set out in IC 12-15-13-3(f)(2). *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-5; filed Oct 31, 1994, 3:30 p.m.: 18 IR 864; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3374; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 2. Inspection of Care in Long Term Care Facilities

NOTE: 405 IAC 1-2 was transferred from 470 IAC 5-2.1. Wherever in any promulgated text there appears a reference to 470 IAC 5-2.1, substitute 405 IAC 1-2.

405 IAC 1-2-1 Inspection (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Oct 12, 1995, 1:30 p.m.: 19 IR 350)*

Rule 3. Criteria for Level of Care in Long Term Care Facilities

NOTE: 405 IAC 1-3 was transferred from 470 IAC 5-3. Wherever in any promulgated text there appears a reference to 470 IAC 5-3, substitute 405 IAC 1-3.

405 IAC 1-3-1 Skilled nursing services; unskilled services

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

Sec. 1. (a) Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis, essentially seven (7) days a week.

(b) Rehabilitation services for an acute rehabilitative condition may be provided at either skilled or intermediate level of care, depending upon the resident's overall condition and nursing care needs. To qualify to skilled rehabilitation services, the following conditions shall be met:

(1) The services are ordered by a physician and must be required and provided at least five (5) days a week.

(2) The therapy must be of such complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required.

(3) The overall condition of the patient must be such that the judgment, knowledge, and skills of a licensed therapist are required.

(c) If the patient's condition is such that it requires observation and assessment by licensed professional nursing staff to identify or evaluate the patient's need for modification of treatment and the initiation of additional medical procedures until the patient's condition is stabilized, the service is at the skilled level. These services must be documented by physician's orders, progress notes, and nurse's notes. Routine or prophylactic monitoring of a stable condition is considered intermediate level.

(d) When licensed professional nursing staff is required to teach a skilled procedure in order to facilitate discharge to self-care, skilled level of care can be considered short term. This could include teaching self-injection, self-catheterization, catheter care, ostomy care, dressing changes, or suctioning. Nursing care plan and documentation of overall condition must substantiate that discharge to self-care following a training program is a realistic goal. Training programs of longer than thirty (30) days, when no other skilled services are required, will be considered appropriate for the intermediate level of care.

(e) The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan and supervision of personal care does not in itself require skilled level of care. Skilled level of care is appropriate where the sum total of unskilled services that are a necessary part of the medical regimen, when considered in light of the patient's overall condition, makes the significant involvement of skilled nursing personnel necessary to promote the patient's recovery and medical safety. The need for significant skilled personnel involvement must be documented within the patient's medical record.

(f) Based upon the principles in subsections (a) through (e), examples of skilled nursing services include, but are not limited to, the following:

(1) Intravenous infusions or intravenous and intramuscular injections. However, injections which can usually be self-administered, such as the well-regulated diabetic who receives daily insulin injections, would not require skilled services. The occasional or PRN (as needed) intramuscular injection would qualify as a skilled service only if the patient's medical condition is unstable as supported by documentation in the patient's medical records.

(2) Nasogastric tube and gastrostomy feedings.

(3) Nasopharyngeal and tracheotomy aspiration. However, patients with tracheotomy tubes which have been used over a long period of time and where the patient is mentally able to perform this care with little, if any, supervision would not qualify for skilled level of care.

(4) Insertion and sterile irrigation or replacement of catheters. Skilled care may be required for patients in whom catheter obstructions frequently occur necessitating the intervention of professional personnel. The sterile irrigation of catheters must be ordered by the physician specifying the type of irrigation and length of time which the sterile irrigations are to continue. Routine sterile irrigations continuing longer than fourteen (14) days will be considered appropriate for intermediate level of care.

(5) Complex wound care involving sterile dressings, prescription medications, and aseptic techniques. Justification for these procedures must be fully documented, and the duration of these treatments must be specified by the physician. The necessity for the treatments continuing longer than thirty (30) days must be documented on the patient's record by fully describing the patient's condition.

(6) Care of extensive decubitus ulcers. The size and stage of the decubitus must be documented. The treatment must be

specifically ordered by the physician. Appropriate documentation to monitor the progress of the decubitus is also required.

(7) Initial phases of a regimen involving administration of oxygen. Patients requiring the administration of oxygen on a daily basis for a new or recent medical condition would qualify for skilled level care. However, patients receiving oxygen either continuously or PRN for a chronic, stable medical condition would not qualify for skilled level care.

(g) In order to qualify for skilled level of care, documentation of the medical necessity for increased intensity of nursing services must be noted in physician's orders, progress notes, and nurse's notes. When this intensity of nursing services is no longer required, it is the responsibility of the nursing facility and physician to transfer the resident to the intermediate level of care. The office may initiate an independent evaluation and level of care assessment to determine whether continued reimbursement at the skilled level is justified. *(Office of the Secretary of Family and Social Services; Long Term Care Facilities II; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 269; filed Mar 15, 1988, 1:59 p.m.: 11 IR 2852; filed Mar 10, 1993, 5:00 p.m.: 16 IR 1792; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-3-2) to the Office of the Secretary of Family and Social Services (405 IAC 1-3-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

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

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

Sec. 2. (a) Intermediate nursing care includes care for patients with long term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention. Intermediate care services encompass a range of services from those below skilled level services to those above room and board level services. The determination of the differences between the skilled and intermediate level of care is based upon the patient's condition, along with the complexity and range of medical services required by the patient on a daily basis. The provision of room, food, laundry, and supervision of activities of daily living do not, in and of themselves, qualify as intermediate care.

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

(1) Assistance with ambulation.

(2) Assistance with transfers and positioning.

(3) Assistance with general bathing and hygiene.

(4) Assistance with eating.

(5) Assistance with dressing.

(6) Assistance with toileting/incontinence care.

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

(1) Administration of routine oral medications, eye drops, ointment, or any combination of all of these.

(2) Injections which usually can be self-administered, such as the well-regulated diabetic who receives daily insulin injections. The administration of an occasional or PRN (as needed) intramuscular injection would be considered appropriate for intermediate level of care.

(3) General maintenance care of colostomy or ileostomy, including cleaning colostomy, changing colostomy bags, or routine use of equipment.

(4) Routine insertion and maintenance for patency of indwelling catheters.

(5) Changes of dressings in noninfected, postoperative, or chronic conditions.

(6) Prophylactic and palliative skin care, including bathing and application of medical creams or treatment of minor skin conditions.

(7) Administration of oxygen, after initial phases for a stable, chronic condition.

(8) Routine care of plaster cast and brace patients, including hip spica or body casts.

(9) Heat as palliative treatment.

(10) Provision and supervision of restorative measures.

(11) Provision of skilled services or procedures when the resident's overall condition does not require the intensity of professional nursing services necessary for skilled level of care.

(12) Twenty-four (24) hour a day supervision or direct assistance to maintain safety due to confusion or disorientation that

is not related to, or a result of, mental illness.

(d) The Indiana Medicaid program does not make reimbursement for services below the intermediate level of care. *(Office of the Secretary of Family and Social Services; Long Term Care Facilities III; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 272; filed Mar 15, 1988, 1:59 p.m.: 11 IR 2854; filed Mar 10, 1993, 5:00 p.m.: 16 IR 1794; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-3-3) to the Office of the Secretary of Family and Social Services (405 IAC 1-3-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-3-3 Examples illustrating criteria for level of care; differentiation between skilled and intermediate care

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. The following examples illustrate some of the considerations involved in the differentiation between Skilled and Intermediate care.

SKILLED CARE	INTERMEDIATE CARE
Anemia	
Rapid breakdown of red blood cells which may produce a hemolytic crisis. Treatment – intravenous solutions or transfusions.	Frequently present in the elderly. Oral medication or infrequent injections usually sufficient for routine treatment.
Arteriosclerosic Heart Disease	
Severe vascular heart disease requiring powerful antihypertensive drugs. There may be symptoms of heart failure requiring accurate digitalization and diuretics.	Minimal or moderate amounts of medication without adjustment to medications.
Arthritis	
Drugs used in large doses and over a prolonged period of time that may produce metabolic or toxic symptoms.	Long history of chronic arthritis. Routine medication and physical therapy.
Brain Syndromes (Psychoses)	
Must receive active treatment. (1) Treatment developed by a physician in conjunction with staff members. (2) Services are expected to improve the patient's condition and level of functioning. (3) Services are supervised and evaluated by a physician and documented in the medical record.	Therapy not planned for the particular patient. Activities are diversional in nature, i.e., to provide social or recreational outlet for the patient. Non-energetic treatment with medications.
Bronchitis (chronic) and Bronchiectasis	
Limited pulmonary reserve with changes in oxygen requirements. Intractable congestive heart failure.	Standard oral medication. Patient has been taught to manage own inhalation equipment.
Cataract	
Skilled care required for 14 days because of very recent surgery or complications.	Usually cataract extractions are followed by a normal uncomplicated convalescence in the hospital and discharge to the patient's home.
Cancer	
Recent major surgery. Current treatment with radium, radioactive isotopes, X-ray, and anti-neoplastic agents. Active treatment for serious complications such as severe pain, acute infections, decubiti, fractures, special training while patient learns to handle appliances or surgical wounds, including colostomy.	No specific treatment. Considered arrested. If metastasis, the cancer is not being actively treated.
Cerebrovascular Accident	

Hemiplegia and/or speech disturbance. Less than six months since cerebrovascular accident. Active speech or physical therapy.	Small cerebral vessel involved with minor paralysis (Ischemia Attacks). Patient can ambulate. More than six months since C.V.A.
Cirrhosis of Liver	
Persistent ascites being treated by diuretics, by paracentesis or both.	Bed rest and diet. Moderate use of diuretic drugs.
Congestive Heart Failure	
Patient requires vigorous and comprehensive treatment. Severe shortness of breath, requiring tourniquets on limbs, phlebotomy, or oxygen therapy.	Incipient or mild failure with exertional shortness of breath, fatigue, and perhaps edema of the ankles, which usually subside readily with diuretic and digitalis therapy.
Convulsions	
Frequent attacks due to serious brain diseases, such as tumors, cerebral edema, and cerebrovascular accidents. Difficult to control.	Infrequent attacks that can be controlled or alleviated by medication. Frequency of once a month will be considered skilled care.
Decubitus Ulcer	
Energetic treatment by debridement of necrotic tissue, medications, and bandages. Tissue necrosis and infection must be actively treated.	Minor healing decubiti or skin care to prevent decubiti.
Diabetes Mellitus	
Severe or "brittle" diabetes. Variations in insulin requirements. Also for the juvenile diabetic.	Diabetes easily controlled by diet and oral medication or insulin.
Emotional Disturbances	
To control severe agitation or depression for short period of time, large doses of tranquilizers or anti-depressives are required. Close supervision is required (when IM medications are being given daily).	Anxiety and depression are not severe. Mental condition does not require close continuous supervision.
Emphysema	
"Respiratory cripple" may show symptoms of respiratory infection, severe bronchial secretion, carbon dioxide retention, and cardiac failure. These symptoms require energetic medical treatment.	Symptoms of wheezing, chronic cough, and mild dyspnea which do not require special treatment by skilled personnel. Patient may require IPPB treatment for a period.
Fractures	
Many factors are involved in the amount of skilled care patient requires. Care depends upon the location of the fracture, the degree of healing, the type of treatment, and the severity of any complications.	The healing process is almost complete. Restorative physical therapy may be necessary.
Hypertensive Heart Disease	
Vigorous and diligent treatment for patient showing cerebral signs (encephalopathy) strokes, transient hemiparesis, cardiac insufficiency, coronary ischemia, and severe headaches not controlled by routine analgesics.	Patient has been on long-term antihypertensive therapy or alarming symptoms are absent and the patient is not under vigorous treatment.
Malnutrition	
Condition is so serious that patient requires frequent visits by his physician. I.V. or tube feedings generally required.	Patient's poor eating habits are corrected by special diets.
Myocardial Infarction	

Recent infarction. Relative rest for the injured heart. Possible congestive heart failure.	Attack over 2 – 3 months ago. Routine prophylaxis (anti-coagulants) against thromboembolic complications. Heart compensating.

Nephritis, Nephrosclerosis, Nephroses

Acute phase of these conditions requires active therapy. In the chronic state they may require special treatment for heart failure, electrolyte abnormalities, acidosis and uremia.	Many elderly patients suffer from renal diseases. Treatment often is a dietary regimen and diuretic drugs.

Osteoporosis

Collapse and wedging of the atrophic vertebral bones may appear under minimal stress. Skilled care will be required to treat the fracture or alleviate the pain.	This condition is found in many elderly people. Oral medications may be administered.

(Office of the Secretary of Family and Social Services; Long Term Care Facilities IV; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 273; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-3-4) to the Office of the Secretary of Family and Social Services (405 IAC 1-3-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.

Rule 4. Rate-Setting Criteria for State-Owned Intermediate Care Facilities for the Mentally Retarded

NOTE: 405 IAC 1-4 was transferred from 470 IAC 5-4.2. Wherever in any promulgated text there appears a reference to 470 IAC 5-4.2, substitute 405 IAC 1-4.

405 IAC 1-4-1 Policy; scope (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-2 Definitions (Repealed)

Sec. 2. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location (Repealed)

Sec. 3. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-4 Financial report to department; annual schedule; prescribed form; extensions; penalty for untimely filing (Repealed)

Sec. 4. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-5 New provider; initial financial report to department; criteria for establishing initial interim rates; supplemental report; base rate setting (Repealed)

Sec. 5. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-6 Active providers; rate review; annual request; additional requests; requests due to change in law; request concerning capital return factor; computation of factor (Repealed)

Sec. 6. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-7 Request for rate review; budget component; occupancy level assumptions; effect of inflation

assumptions (Repealed)

Sec. 7. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis (Repealed)

Sec. 8. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-9 Criteria limiting rate adjustment granted by department (Repealed)

Sec. 9. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-10 Computation of rate; allowable costs; review of cost reasonableness (Repealed)

Sec. 10. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-11 Allowable costs; services provided by parties related to provider (Repealed)

Sec. 11. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-12 Allowable costs; capital return factor (Repealed)

Sec. 12. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-13 Allowable cost; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties (Repealed)

Sec. 13. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-14 Allowable costs; capital return factor; computation of return on equity component (Repealed)

Sec. 14. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-15 Allowable costs; capital return factor; use fee; depreciable life; property basis (Repealed)

Sec. 15. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation (Repealed)

Sec. 16. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members (Repealed)

Sec. 17. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses (Repealed)

Sec. 18. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation (Repealed)

Sec. 19. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits (Repealed)

Sec. 20. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-21 Nursing facilities providing intermediate or skilled care; staffing costs; incentive for cost efficiency (Repealed)

Sec. 21. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-22 Routine medical or nonmedical supplies and equipment (Repealed)

Sec. 22. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-23 Nursing facilities providing intermediate and skilled care; reimbursement for therapy services (Repealed)

Sec. 23. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-24 Nursing facilities providing intermediate care and skilled care; allocation of intermediate and skilled care costs (Repealed)

Sec. 24. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-25 State-owned intermediate care facilities for the mentally retarded; allowable costs; compensation; per diem rate (Repealed)

Sec. 25. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-26 Community residential facilities for the developmentally disabled; allowable costs; compensation; per diem rate; incentive payment rate (Repealed)

Sec. 26. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 12, 1993, 5:00 p.m.: 16 IR 1789)*

405 IAC 1-4-26.1 Community residential facilities for the developmentally disabled; allowable costs; compensation; per diem rate; incentive payment rate (Repealed)

Sec. 26.1. *(Repealed by Office of the Secretary of Family and Social Services; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2331)*

405 IAC 1-4-27 Administrative reconsideration; appeal (Repealed)

Sec. 27. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-28 Nursing facilities; separate reimbursement for ventilator units in nursing homes (Repealed)

Sec. 28. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-29 Skilled nursing facilities; separate reimbursement for brain and high spinal cord trauma and major progressive neuromuscular disorders (Repealed)

Sec. 29. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-30 Skilled nursing facilities; separate reimbursement for "chronically medically dependent" people infected by the human immunodeficiency virus (HIV) (Repealed)

Sec. 30. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-31 Skilled nursing facilities; separate reimbursement for "chronically medically dependent" people infected by the human immunodeficiency virus (HIV) (Repealed)

Sec. 31. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

Rule 4.1. Rate-Setting Criteria for Home Health Agencies

405 IAC 1-4.1-1 Policy; scope

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

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

(b) In accordance with federal law, reimbursement for home health services will be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available to Medicaid recipients at least to the extent that such care and services are available to the general population in the geographic area. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.1-1; filed Aug 3, 1993, 4:00 p.m.: 16 IR 2840; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-4.1-2 Definitions

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

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

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

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

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

(e) "Prior authorization" has the meaning set forth in 405 IAC 1-6-2 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]*.

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

(g) "Staffing cost rate" means the service-specific standard wage rate paid per billable hour and based upon standard personnel-related costs that are a function of staff time spent in the performance of patient care activities, plus a multiplier representing fringe benefits.

(h) "Semivariable cost rate" means fifteen percent (15%) of the overhead cost rate that is reallocated from the overhead cost rate to the staffing cost rate.

(i) "Standard wage rate" means a wage rate assigned to specific home health services.

(j) "Health Care Financing Administration home health agency input price index" means the index of that name published quarterly by DRI/McGraw-Hill. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.1-2; filed Aug 3, 1993, 4:00 p.m.: 16 IR 2840; filed Mar 31, 1995, 4:30 p.m.: 18 IR 2021, eff Jun 1, 1995; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-4.1-3 Home health care services; general information

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

Sec. 3. (a) Indiana Medicaid will reimburse providers for the following home health services:

(1) Skilled nursing performed by a registered nurse or licensed practical nurse.

(2) Home health aide services.

(3) Physical, occupational, and respiratory therapies.

(4) Speech pathology services.

(5) Renal dialysis.

The services in this subsection must be performed in the home and provided within the limitations set forth in 405 IAC 1-6-11 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]*.

(b) Except as provided in subsection (c), all home health services require prior authorization by submitting a properly completed written request to the office or its contractor. Prior authorization procedures for home health care are set forth in 405 IAC 1-6-11 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]*.

(c) Prior authorization may be obtained by telephone under the circumstances and subject to the limitations set forth in 405 IAC 1-7-3(a)(3)(C) *[405 IAC 1-7 was repealed filed Jul 7, 1997, 4:00 p.m.: 20 IR 3365.]*. Services ordered in writing by a physician prior to the patient's discharge from a hospital within the limitations set forth in 405 IAC 1-6-11 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]* do not need prior authorization. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.1-3; filed Aug 3, 1993, 4:00 p.m.: 16 IR 2841; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-4.1-4 Home health care services; reimbursement methodology

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

Sec. 4. (a) Home health agency rates set in calendar year 1993 may not exceed the maximum statewide unit-of-service rates that were in effect in calendar year 1987, multiplied by the rate of increase in the Health Care Financing Administration home health agency input price index that occurred between the end of calendar year 1987 and the end of calendar year 1992.

(b) Beginning with any revised rates set during calendar year 1995, home health agencies will be reimbursed for covered services provided to Medicaid recipients through standard, statewide rates, computed as follows:

(1) the overhead cost rate; plus

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

to equal the total reimbursement per visit.

(c) The overhead cost rate is a flat, statewide rate, based on the statewide weighted median overhead cost per visit. The statewide weighted median overhead cost per visit is derived in the following manner:

(1) Determine for each HHA, total reimbursable Medicare costs from the standard Medicare cost report submitted by HHA providers, less direct staffing costs, divided by the total number of HHA visits during the Medicare reporting period for that provider. The result of this calculation is an overhead cost per visit for each HHA.

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

(3) Calculate the cumulative number of visits for all agencies.

(4) The statewide median overhead cost per visit is the cost of the agency at the point in the accumulation of visits in which half of the visits are provided by higher-cost agencies, and half are provided by lower-cost agencies.

(d) For purposes of determining the overhead cost rate, beginning with the rates set during calendar year 1995, the most recently filed Medicare cost reports will be accepted. Beginning with the rates set during calendar year 1996 and after, providers

must submit information on forms prescribed by the office, including the most recently filed Medicare cost report. The data from each specific reporting year will be inflated forward to a common point in time using the DRI/McGraw-Hill home health agency input price index.

(e) The staffing cost rate will be equal to the standard wage rate, multiplied by a percentage to account for fringe benefits. The standard wage rate will be determined as follows:

(1) Beginning with any rates set during calendar year 1995, wage rates will be collected from the latest Marion Merrell Dow Long Term Care Digest/Home Care Industry survey specific to the East North Central geographic region and will be multiplied by one and two-tenths (1.2) representing fringe benefits.

(f) The semivariable cost rate will be removed from the overhead cost rate calculated in accordance with section 4(c) *[subsection (c)]* and added to the standard wage rate calculated in accordance with section 4(e) *[subsection (e)]*, based on billable hours of service.

(g) For rates calculated in calendar year 1995, a uniform statewide one (1) time transition adjustment will be added to all staffing and overhead rates to assure that aggregate home health agency Medicaid reimbursement is no less than it would have been if the rate-setting system established in this section had been in place in calendar year 1994. The one (1) time transition adjustment will be calculated by the office.

(h) Field audits will be conducted yearly on a selected number of home health agencies.

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

(1) Medicare cost reports.

(2) Statistical data.

Refusal to submit requested documentation will result in penalties assessed by the office and set forth in IC 12-15-22-1.

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

(1) A field audit identifies overpayment by Medicaid.

(2) A field audit or investigation determines that Medicaid paid more than other payers for like services provided before September 2, 1993.

(3) The provider knowingly receives overpayment of a Medicaid claim from the office. In this event, the provider must complete appropriate Medicaid billing adjustment forms and reimburse the office for the amount of the overpayment.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.1-4; filed Aug 3, 1993, 4:00 p.m.: 16 IR 2842; filed Mar 31, 1995, 4:30 p.m.: 18 IR 2022, eff Jun 1, 1995; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Rule 4.2. Home Health Services

405 IAC 1-4.2-1 Policy; scope

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

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

(b) In accordance with federal law, reimbursement for home health services will be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available to Medicaid recipients at least to the extent that such care and services are available to the general population in the geographic area. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-1; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3375; filed Oct 8, 1998, 12:23 p.m.: 22 IR 433; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-4.2-2 Definitions

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

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

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

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

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

(e) "Prior authorization" has the meaning set forth in 405 IAC 1-6-2 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]*.

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

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

(h) "Semi-variable cost" means that portion of the overhead cost that is reallocated from the overhead cost to the staffing cost. It consists of:

(1) direct supervision;

(2) routine medical supplies;

(3) transportation; and

(4) any other semi-variable expenses that must be covered by Medicaid under federal law.

(i) "Health Care Financing Administration Home Health Agency Market Basket" means the index of that name published quarterly by DRI/McGraw-Hill.

(j) "Forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(k) "Hours worked" means the number of total hours paid for home health agency personnel, less the number of hours paid for vacation, holiday, and sick pay. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-2; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3375; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1116; filed Oct 8, 1998, 12:23 p.m.: 22 IR 433; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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

Sec. 3. (a) Indiana Medicaid will reimburse HHA providers for the following home health services:

(1) Skilled nursing performed by a registered nurse or licensed practical nurse.

(2) Home health aide services.

(3) Physical and occupational therapies.

(4) Speech pathology services.

(5) Renal dialysis.

The services in this subsection must be performed in the home and provided within the limitations set forth in 405 IAC 1-6-11 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]*.

(b) Except as provided in subsection (c), all home health services require prior authorization by submitting a properly completed written request to the office or its contractor. Prior authorization procedures for home health care are set forth in 405 IAC 1-6-11 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]*.

(c) Prior authorization may be obtained by telephone under the circumstances and subject to the limitations set forth in 405 IAC 1-7-3(a)(3)(C) *[405 IAC 1-7 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]*. Services ordered in writing by a physician prior to the patient's discharge from a hospital within the limitations set forth in 405 IAC 1-6-11 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]* do not need prior authorization. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-3; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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

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

(b) Extension of the one hundred fifty (150) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

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

(d) When an annual financial report is sixty (60) days past due and an extension has not been granted, the office shall notify the provider that the provider's participation in the Indiana Medicaid program shall be terminated. The termination shall be effective on the first day of the month following the ninetieth (90th) day the annual financial report is past due unless the provider submits the delinquent annual financial report before that date. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-3.1; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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

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

(1) the overhead cost rate; plus

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

to equal the total reimbursement per visit.

(b) The overhead cost rate is a flat, statewide rate based on the statewide weighted median overhead cost per visit. The statewide weighted median overhead cost per visit is derived in the following manner:

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

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

(3) Calculate the cumulative number of Medicaid visits for all agencies.

(4) The statewide weighted median overhead cost per visit is the cost of the agency at the point in the accumulation of visits in which half of the Medicaid visits are provided by higher-cost agencies and half are provided by lower-cost agencies.

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

(1) Registered nurse.

(2) Licensed practical nurse.

(3) Home health aide.

(4) Physical therapist.

(5) Occupational therapist.

(6) Speech pathologist.

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

(1) Determine for each HHA total patient-related direct staffing and benefit costs submitted by HHA providers on forms prescribed by the office, divided by the total number of HHA hours worked during the Medicaid reporting period for that provider for each discipline. The result of this calculation is a staffing cost rate per hour for each HHA and discipline.

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

(3) Calculate the cumulative number of Medicaid hours by all disciplines for all agencies.

(4) The statewide weighted median staffing cost rate per hour for each discipline is the cost of the agency at the point in the accumulation of hours in which half of the Medicaid hours are provided by agencies with higher staffing rates per hour and half are provided by agencies with lower staffing rates per hour.

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

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

(g) Rate setting shall be prospective, based on the provider's initial or annual cost report for the most recent completed period. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation using the Health Care Financing Administration Home Health Agency input price index. He *[sic.]* inflation adjustment shall apply from the mid-point of the initial or annual cost report period to the mid-point of the next expected rate period.

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

(i) Field audits will be conducted yearly on a selected number of home health agencies.

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

(1) Medicaid cost reports.

(2) Medicare cost reports.

(3) Statistical data.

(4) Financial statements.

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

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

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

(1) A field audit identifies overpayment by Medicaid.

(2) A field audit or investigation determines that Medicaid paid more than other payers for like services provided before September 2, 1993.

(3) The provider knowingly receives overpayment of a Medicaid claim from the office. In this event, the provider must complete appropriate Medicaid billing adjustment forms and reimburse the office for the amount of the overpayment.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-4; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 332; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-4.2-5 Home health care services; annual adjustments

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

Sec. 5. New rates set after January 1, 1997, shall be effective on January 1 and shall be annually adjusted thereafter based upon the most recently submitted financial and statistical documentation as filed by all providers of services who billed Medicaid for services provided during the cost report period. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-5; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3377; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1119; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 4.3. Additional Rate-Setting Criteria for Nursing Facilities, Community Residential Facilities for the Developmentally Disabled, and Intermediate Care Facilities for the Mentally Retarded

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

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

Sec. 1. (a) Notwithstanding 405 IAC 1-4, 405 IAC 1-12, and 405 IAC 1-14 *[405 IAC 1-14 was repealed filed Dec 27, 1994, 3:45 p.m.: 18 IR 1260.]*, the criteria in this section apply to litigation expenses for nursing facilities, intermediate care facilities for the mentally retarded, and community residential facilities for the developmentally disabled.

(b) Legal fees, expenses related to expert witnesses, accounting fees, and other consulting fees shall not be reimbursed by the office as reasonably related medical expenses under the Medicaid program if the expenses are incurred as the result of an administrative or judicial action or proceeding against any agency of the state or the federal government. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.3-1; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2853; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 5. Provider Records

NOTE: 405 IAC 1-5 was transferred from 470 IAC 5-5. Wherever in any promulgated text there appears a reference to 470 IAC 5-5, substitute 405 IAC 1-5.

405 IAC 1-5-1 Medical records; contents and retention

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 records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program.

(b) All providers participating in the Indiana Medicaid program shall maintain, for a period of three (3) years from the date Medicaid services are provided, such medical and/or other records, including x-rays, as are necessary to fully disclose and document the extent of the services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. A copy of a claim form which has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records which are independent of claims for reimbursement. Such medical and/or other records shall include, at the minimum, the following information and documentation:

(1) Identity of the individual to whom service was rendered.
(2) Identity of the provider rendering the service.
(3) Identity and position of provider employee rendering the service, if applicable.
(4) Date on which the service was rendered.
(5) Diagnosis of medical condition of the individual to whom service was rendered, relevant to physicians and dentists only.
(6) Detailed statement describing services rendered.
(7) Location at which services were rendered.
(8) Amount claimed through the Indiana Medicaid program for each specific service rendered.
(9) 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 treatment, must be attached to the prior authorization request and available for audit purposes.
(10) When a recipient is enrolled in therapy, and when required under Medicaid program rules, physician progress notes as to the necessity and effectiveness of therapy and on-going evaluations to assess progress and redefine goals must be a part of the therapy program.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-110; filed Aug 16, 1979, 3:30 p.m.: 2 IR 1383; filed Sep 23, 1982, 9:55 a.m.: 5 IR 2351; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3298; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 5-5-1) to the Office of the Secretary of Family and Social Services (405 IAC 1-5-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-5-2 Disclosure of medical records

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 12-15-22

Sec. 2. Records maintained by providers under section 1 of this rule shall be openly and fully disclosed and produced to the office of Medicaid policy and planning or any authorized representative, designee, or agent thereof, forthwith, upon reasonable notice and request. Such notice and request may be made in person, in writing, or by telephonic means. Failure on the part of any provider to comply with this section shall constitute an abuse of the Medicaid program under IC 12-15-22 and applicable federal law. *(Office of the Secretary of Family and Social Services; 405 IAC 1-5-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3299; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-5-3 Provider financial records used in rate setting; retention
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. Providers whose reimbursement is determined by the office of Medicaid policy and planning must maintain financial records for a period of not less than three (3) years following submission of financial data to the office. A provider must disclose this financial data when the information is to be used during the rate determination process, as well as during audit proceedings. *(Office of the Secretary of Family and Social Services; 405 IAC 1-5-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3299; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 6. Medicaid Covered Services and Limitations (Repealed)
(Repealed by Office of the Secretary of Family and Social Services; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365)

Rule 7. Medicaid Medical Policy (Repealed)
(Repealed by Office of the Secretary of Family and Social Services; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365)

Rule 8. Hospital Reimbursement for Outpatient Services
NOTE: 405 IAC 1-8 was transferred from 470 IAC 5-11. Wherever in any promulgated text there appears a reference to 470 IAC 5-11, substitute 405 IAC 1-8.

405 IAC 1-8-1 Prospective reimbursement methodology (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Dec 2, 1993, 2:00 p.m.: 17 IR 737)*

405 IAC 1-8-2 Policy; scope
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 2. (a) Reimbursement for outpatient hospital services as defined by 42 CFR 440.20(a) is available to providers enrolled by the office of Medicaid policy and planning (office) as Medicaid providers who are in good standing. Continued participation in the Medicaid program and payment for outpatient hospital services are contingent upon maintenance of state licensure and conformance with the office's provider agreement.

(b) The methodology for the reimbursement described in subsection (a) shall be based on set fee schedule allowances for each procedure or occurrence, as established by the office of Medicaid policy and planning. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-2; filed Dec 2, 1993, 2:00 p.m.: 17 IR 735; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-8-3 Reimbursement methodology
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 3. (a) The reimbursement methodology for all covered outpatient services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure, as provided in this section. All services will be billed on the uniform billing form, using both revenue codes and HCPCS codes. The appropriate HCPCS code, if one exists for

the billed procedure, will be required in addition to the revenue code.

(b) Surgical procedures shall be classified into a group corresponding to the Medicare Ambulatory Surgical Center (ASC) methodology and shall be paid a rate established for each ASC payment group. Outpatient surgeries which are not classified into the nine (9) groups designated by Medicare will be classified by the office into one (1) of those nine (9) groups, or additional payment groups. Reimbursement will be based on a blended rate equal to fifty percent (50%) of the Medicare ASC rate and fifty percent (50%) of the fiscal year 1992 Indiana Medicaid statewide median allowed amount for that service. Hospitals will bill for surgeries using a HCPCS code.

(c) Emergency care (as identified by the outpatient hospital department) payment will be based on a statewide fee schedule per HCPCS code. The fee schedule amount will be equal to the Indiana Medicaid statewide median amount paid per service during fiscal year 1992. Claims for services designated as emergency by a hospital will be subject to audit on a postpayment basis to validate that a bona fide emergency existed.

(d) Nonemergency care, determined by the office and as identified by nonemergency diagnosis codes, that is provided in an emergency room, shall be paid based upon a nonemergency setting (for example, a clinic) fee schedule established by the office. This fee schedule amount will be equal to the Indiana Medicaid statewide median amount paid per service during fiscal year 1992. Hospitals will bill using HCPCS codes.

(e) Reimbursement for laboratory procedures and the technical component of radiology procedures shall be based on ninety-five percent (95%) of the Medicare allowance that was in effect prior to federal adoption of the Resource Based Relative Value Scale (RBRVS) for Medicare services. These services will be billed by HCPCS.

(f) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section (for example, therapies, testing, etc.) shall be equal to the Indiana Medicaid statewide median amount paid per service during fiscal year 1992. All other services will be billed using a combination of HCPCS and revenue codes.

(g) The established rates for hospital outpatient reimbursement shall be reviewed annually by the office and adjusted, as necessary, in accordance with this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-3; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-8-4 Client copayment

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

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

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

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

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

(e) The following categories of recipients and services are exempt from the copayment requirements:

(1) Services provided to children under eighteen (18) years of age.

(2) Services provided to pregnant women.

(3) Family planning services.

(4) Services provided by a health maintenance organization (HMO) to recipients enrolled in an HMO.

(5) Medicaid recipients residing in participating long term care facilities.

(f) The copayment shall be made by the recipients and collected by the provider. Medicaid reimbursement shall be adjusted to reflect the copayment amount. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-4; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 9. Reimbursement for Inpatient Psychiatric Services (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59)

Rule 10. Reimbursement for Inpatient Hospital Services (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59)

Rule 10.5. Reimbursement for Inpatient Hospital Services

405 IAC 1-10.5-1 Policy; scope

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

Sec. 1. Reimbursement for inpatient hospital services, as defined by 42 CFR 440.10, is available to providers enrolled by the office of Medicaid policy and planning (office) as Medicaid providers and who are in good standing. Continued participation in the Medicaid program and payment of inpatient hospital services are contingent upon maintenance of state licensure and conformance with the office's provider agreement. 405 IAC 5-17 and 405 IAC 5-28 establish criteria for providing inpatient hospital services to Medicaid recipients and set forth the types of services for which Medicaid reimbursement may be available. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-1; filed Oct 5, 1994, 11:10 a.m.: 18 IR 243; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1082; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 55)*

405 IAC 1-10.5-2 Definitions

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1; IC 12-24-1-3; IC 12-25; IC 16-21

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

(b) "Allowable costs" means Medicare allowable costs as defined by 42 U.S.C. 1395(f).

(c) "All patient DRG grouper" refers to a classification system used to assign inpatient stays to DRGs.

(d) "Base amount" means the rate per Medicaid stay which is multiplied by the relative weight to determine the DRG rate.

(e) "Base period" means the fiscal years used for calculation of the prospective payment rates, including base amounts and relative weights.

(f) "Capital costs" are costs associated with the capital costs of the facility. Capital costs include, but are not limited to, the following:

(1) Depreciation.

(2) Interest.

(3) Property taxes.

(4) Property insurance.

(g) "Children's hospital" means a freestanding general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a children's hospital; or

(2) furnishes services to inpatients who are predominantly individuals under the age of eighteen (18), as determined using the same criteria used by the Medicare program to determine whether a hospital's services are furnished to inpatients who are predominantly individuals under the age of eighteen (18).

"Freestanding" does not mean a wing or specialized unit within a general acute care hospital.

(h) "Cost outlier case" means a Medicaid stay that exceeds a predetermined threshold, defined as the greater of twice the DRG rate or a fixed dollar amount established by the office. The initial fixed dollar amount for the threshold is twenty-five thousand dollars ($25,000). This amount may be changed at the time the relative weights are adjusted.

(i) "Diagnosis-related group" or "DRG" means a classification of an inpatient stay according to the principal diagnosis, procedures performed, and other factors that reflect clinically cohesive groupings of inpatient hospital stays utilizing similar hospital resources. Classification is made through the use of the all patient (AP) DRG grouper.

(j) "Discharge" means the release of a patient from an acute care facility. Patients may be discharged to their home, another health care facility, or due to death. Transfers from one (1) unit in a hospital to another unit in the same hospital shall not be considered a discharge unless one (1) of the units is paid according to the level-of-care approach.

(k) "DRG daily rate" means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the average length of stay for all stays classified into the DRG.

(l) "DRG rate" means the product of the relative weight multiplied by the base amount. It is the amount paid to reimburse

hospitals for routine and ancillary costs of providing care for an inpatient stay.

(m) "Hospital Market Basket Index" means the DRI-Type Hospital Market Basket Index, published quarterly by DRI/McGraw-Hill in "Health Care Costs".

(n) "Inpatient" means a patient who was admitted to a medical facility on the recommendation of a physician and who received room, board, and professional services in the facility.

(o) "Inpatient hospital facility" means:

(1) a general acute hospital licensed under IC 16-21;

(2) a mental health institution licensed under IC 12-25;

(3) a state mental health institution under IC 12-24-1-3; or

(4) a rehabilitation inpatient facility.

(p) "Less than one-day stay" means a medical stay of less than twenty-four (24) hours that is paid according to a DRG rate.

(q) "Level-of-care case" means a medical stay, as defined by the office, that is not part of the DRG reimbursement system. Level-of-care cases include psychiatric cases, rehabilitation cases, and certain burn cases.

(r) "Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure that is not paid through the DRG payment system.

(s) "Long term care hospital" means a freestanding general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a long term hospital; or

(2) has an average inpatient length of stay greater than twenty-five (25) days as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days.

"Freestanding" does not mean a wing or specialized unit within a general acute care hospital.

(t) "Medicaid day" means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day.

(u) "Medicaid stay" means an episode of care provided in an inpatient setting that includes at least one (1) night in the hospital and is covered by the Indiana Medicaid program.

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

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

(x) "Outlier payment amount" means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

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

(z) "Principal diagnosis" means the diagnosis, as described by ICD-9-CM code, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

(aa) "Readmission" means that a patient is admitted into the hospital within fifteen (15) days following a previous hospital admission and discharge for a related condition as defined by the office.

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

(cc) "Relative weight" means a numeric value which reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

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

(ee) "Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient from one (1) unit to another unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

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

(gg) "Transferring hospital" means the hospital that initially admits and then discharges the patient to another hospital. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-2; filed Oct 5, 1994, 11:10 a.m.: 18 IR 244; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1082; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1514; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 55)*

405 IAC 1-10.5-3 Prospective reimbursement methodology

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

Sec. 3. (a) The purpose of this section is to establish a prospective, cost-based reimbursement methodology for services provided by inpatient hospital facilities that are covered by the state of Indiana Medicaid program. The methodology for reimbursement described in this section shall be a prospective system wherein a payment rate for each hospital stay will be established according to a DRG reimbursement methodology or a level-of-care reimbursement methodology. Prospective payment shall constitute full reimbursement. There shall be no year-end cost settlement payments.

(b) Rebasing of the DRG and level-of-care methodologies will apply information from the most recent available cost report that has been filed and audited by the office or its contractor.

(c) Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate, the medical education rate, and, if applicable, the outlier payment amount.

(d) Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate, the medical education rate, and, if applicable, the outlier payment amount (burn cases only).

(e) Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all patient DRG grouper.

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

(g) Initial relative weights were calculated using Indiana Medicaid claims data for inpatient stays with dates of admission within state fiscal years 1990, 1991, and 1992 and cost report data from facilities' fiscal year 1990 cost reports. Relative weights will be reviewed by the office and adjusted no more often than annually by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. Interim adjustments to the relative weights will not be made except in response to legislative mandates affecting Medicaid participating hospitals. Each legislative mandate will be evaluated individually to determine whether an adjustment to the relative weights will be made. DRG average length of stay values and outlier thresholds will be revised when relative weights are adjusted.

(h) Initial base amounts were calculated using cost report data from facilities' fiscal year 1990 as-settled cost reports. Cost report data were inflated to the midpoint of the state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index available at the end of the 1993 calendar year. Base amounts will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. In the absence of rebasing, base amounts will be inflated annually according to the Hospital Market Basket Index published in the second quarter of the current year.

(i) The office may establish a separate base amount for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate base amount. Children's hospitals with a case mix adjusted cost per discharge greater than one (1) standard deviation above the mean cost per discharge for DRG services will be eligible to receive the separate base amount established under this subsection. The separate base amount is equal to one hundred and twenty percent (120%) of the statewide base amount for DRG services.

(j) Initial level-of-care payment rates were calculated using Indiana Medicaid claims data for inpatient stays with dates of admission within state fiscal years 1990, 1991, and 1992 and cost report data from facilities' fiscal year 1990 cost reports. Cost report data was inflated to the midpoint of the state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index. Level-of-care rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. In the absence of rebasing, level-of-care rates will be inflated annually according to the Hospital Market Basket Index published in the second quarter of the current year. The office shall not set separate level-of-care rates for different categories of facilities, except as specifically noted in this section.

(k) Level-of-care cases are categorized as DRG numbers 424–428, 429 (excluding diagnosis code 317.XX–319.XX), 430–432, 456–459, 462, and 472, as defined and grouped using the all patient DRG grouper, version 14.1. These DRG numbers represent burn, psychiatric, and rehabilitative care.

(l) In addition to the burn level-of-care rate, the office may establish an enhanced burn level-of-care rate for hospitals with specialized burn facilities, equipment, and resources for treating severe burn cases. In order to be eligible for the enhanced burn rate, facilities must be designated as offering a burn intensive care unit.

(m) The office may establish separate level-of-care rates for children's hospitals to the extent necessary to reflect significant

differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate level-of-care rate. Children's hospitals with a cost per day greater than one (1) standard deviation above the mean cost per day for level-of-care services will be eligible to receive the separate base amount. Determinations will be made for each level-of-care category. The separate base amount is equal to one hundred twenty percent (120%) of the statewide level-of-care rate.

(n) The office may establish separate level-of-care rates, policies, billing instructions, and frequency for long term care hospitals to the extent necessary to reflect differences in treatment patterns for patients in such facilities. Hospitals must meet the definition of long term hospital set forth in this rule to be eligible for the separate level-of-care rate.

(o) Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. The initial flat, statewide per diem capital rate was calculated using cost report data from facilities' fiscal year 1990 cost reports, inflated to the midpoint of state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index and adjusted to reflect a minimum occupancy level for non-nursery beds of eighty percent (80%). Capital per diem rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the capital costs associated with efficiently providing hospital services. In the absence of rebasing, the per diem capital rate will be inflated annually using the Hospital Market Basket Index published in the second quarter of the current year.

(p) The capital payment amount for Medicaid stays reimbursed under the DRG methodology shall be equal to the product of the per diem capital rate and the average length of stay for all cases within the particular DRG. Medicaid stays reimbursed under the level-of-care methodology will be paid the per diem capital rate for each covered day of care. The office shall not set separate capital per diem rates for different categories of facilities, except as specifically noted in this rule.

(q) Medical education rates shall be prospective, hospital-specific per diem amounts. The medical education payment amount for stays reimbursed under the DRG methodology shall be equal to the product of the medical education per diem rate and the average length of stay for the DRG. Payment amounts for medical education for stays reimbursed under the level-of-care methodology shall be equal to the medical education per diem rate for each covered day of care.

(r) Facility-specific, per diem medical education rates shall be based on costs per resident per day multiplied by the number of residents reported by the facility. Initial costs per resident per day were determined according to each facility's fiscal year 1990 cost report. In subsequent years, but no more often than every second year, the office will use the most recent cost report data to determine a cost per resident per day that more accurately reflects the cost of efficiently providing hospital services. The number of residents will be determined according to the most recent available cost report that has been filed and audited by the office or its contractor. In the absence of rebasing, the medical education per diem will be inflated annually using the Hospital Market Basket Index published in the second quarter of the current year.

(s) Medical education payments will only be available to hospitals that continue to operate medical education programs. Hospitals must notify the office within thirty (30) days following discontinuance of their medical education program.

(t) For hospitals with new medical education programs, the medical education per diem will be effective no earlier than two (2) months prior to notification to the office that the program has been implemented. The medical education per diem shall be based on the most recent reliable claims data and cost report data.

(u) Cost outlier cases are determined according to a threshold established by the office. For purposes of establishing outlier payment amounts, prospective determination of costs per inpatient stay shall be calculated by multiplying a cost-to-charge ratio by submitted and approved charges. Outlier payment amounts shall be equal to a percentage of the difference between the prospective cost per stay and the outlier threshold amount. Cost outlier payments are not available for cases reimbursed using the level-of-care methodology, except for burn cases that exceed the established threshold.

(v) Readmissions will be treated as separate stays for payment purposes, but will be subject to medical review. If it is determined that a discharge is premature, payment made as a result of the discharge or readmission may be subject to recoupment.

(w) Special payment policies shall apply to transfer cases. The transferee, or receiving, hospital is paid according to the DRG methodology or level-of-care methodology. The transferring hospital is paid the sum of the following:

(1) A DRG daily rate for each Medicaid day of the recipient's stay, not to exceed the appropriate full DRG payment, or the level-of-care per diem payment rate for each Medicaid day of care provided.

(2) The capital per diem rate.

(3) The medical education per diem rate. Certain DRGs are established to specifically include only transfer cases; for these DRGs, reimbursement shall be equal to the DRG rate.

(x) Special payment policies shall apply to less than one-day stays that are paid according to a DRG rate. For less than one-day stays, hospitals will be paid a DRG daily rate, the capital per diem rate for one (1) day of stay, and the medical education per diem

rate for one (1) day of stay, if applicable. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-3; filed Oct 5, 1994, 11:10 a.m.: 18 IR 245; filed Nov 16, 1995, 3:00 p.m.: 19 IR 664; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1083; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1515; errata filed Mar 21, 1997, 9:45 a.m.: 20 IR 2116; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 57; errata filed Jan 25, 2002, 2:27 p.m.: 25 IR 1906)*

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

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

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

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

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

(d) Outlier payments for inpatient stays reimbursed under subsection (b) shall be determined according to the methodology described in section 3 of this rule; however, for purposes of estimating costs, the statewide cost-to-charge ratio shall be used.

(e) To be eligible for a facility-specific per diem medical education rate, out-of-state providers must be located in a city listed in 405 IAC 5-5-2(a)(3) through 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Indiana Medicaid inpatient days. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for this reimbursement.

(f) To be considered for a separate base amount for children's hospitals, out-of-state children's hospitals must be located in a city listed in 405 IAC 5-5-2(a)(3) through 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Indiana Medicaid inpatient days. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for a separate base amount. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-4; filed Oct 5, 1994, 11:10 a.m.: 18 IR 246; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1084; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1517; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59)*

Rule 11. Reimbursement for Services Performed by Physicians, Limited License Practitioners, and Nonphysician Practitioners (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59)

Rule 11.5. Reimbursement for Services Performed by Physicians, Limited License Practitioners, and Nonphysician Practitioners

405 IAC 1-11.5-1 Policy; scope

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

Sec. 1. (a) Reimbursement for physician services, limited license practitioner services, and nonphysician practitioner services as defined by 42 CFR 440.50 and 42 CFR 440.60(a) is available to providers licensed by the health professions bureau and enrolled by the office of Medicaid policy and planning (office) as Medicaid providers who are in good standing. Continued participation in the Medicaid program and payment for services is contingent upon maintenance of state licensure and conformance with the office's provider agreement.

(b) The reimbursement policy established by this rule applies to claims with dates of service on and after its effective date. For claims with dates of service prior to the effective date of this rule, the interim reimbursement policy established by 405 IAC 1-11 applies.

(c) As used in this rule, "physician and limited license practitioner (LLP)" means any of the following:

(1) A doctor of medicine.

(2) A doctor of osteopathy.
(3) A physician group practice.
(4) A primary care group practice.
(5) An optometrist.
(6) A podiatrist.
(7) A dentist who is an oral surgeon.
(8) A chiropractor.
(9) A health service provider in psychology.
(d) As used in this rule, "nonphysician practitioner" or "NPP" means any of the following:
(1) A physical therapist.
(2) An occupational therapist.
(3) A respiratory therapist.
(4) An audiologist.
(5) A speech therapist.
(6) A licensed psychologist.
(7) An independent laboratory or radiology provider.
(8) A dentist who is not an oral surgeon.
(9) A social worker certified through the American Academy of Certified Social Workers (ACSW) or who has a master of social work (MSW) degree, a psychologist with a basic certificate, or a licensed psychologist providing outpatient mental health services in a physician-directed outpatient mental health facility.
(10) An advance practice nurse.
(11) A physician's assistant.
(12) A mental health professional listed in 405 IAC 1-6-13.1(c)(4) through 405 IAC 1-6-13.1(c)(5) *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]* and 405 IAC 1-7-20.1(c)(4) through 405 IAC 1-7-20.1(c)(5) *[405 IAC 1-7 was repealed filed Jul 7, 1997, 4:00 p.m.: 20 IR 3365.]*.

(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-1; filed Sep 6, 1994, 3:25 p.m.: 18 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-11.5-2 Reimbursement methodology

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

Sec. 2. (a) The office shall establish fee schedules with maximum allowable payment amounts for services and procedures covered under the Medicaid program and provided by eligible physicians, LLPs, and other NPPs.
(b) The reimbursement for services of physicians and LLPs shall be determined as follows:
(1) Reimbursement for services of physicians and LLPs, except services of the physicians in subdivisions (3) through (10) shall be equal to the lower of the following:
(A) The submitted charges for the procedure.
(B) The established fee schedule allowance for the procedure. The statewide established fee schedule allowance for the procedure is based on the Medicare relative value unit for an Indiana urban locality multiplied by the conversion factor for the procedure as established by the office of Medicaid policy and planning (office).
(2) If no Medicare relative value unit, as defined in this section, exists for a procedure, reimbursement will be established as follows:
(A) Relative value units may be obtained from other state Medicaid programs or may be developed specifically for the Indiana Medicaid program, subject to review by the Medicaid director.
(B) For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement will be made using the fee value in the national Medicare clinical laboratory fee schedule.
(3) The office may set reimbursement for specific procedure codes using a different methodology from that specified in subdivisions (1) and (2) in order to preserve access to the specific service.
(4) Reimbursement for services of anesthesiologists shall be based on a statewide fee schedule. The statewide fee schedule for anesthesiology services is based on the total base and time units for the procedure multiplied by the conversion factor as

established by the office.

(5) Reimbursement for services of assistant surgeons shall be equal to twenty percent (20%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).

(6) Reimbursement for services of cosurgeons shall be paid at sixty-two and one-half percent (62.5%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).

(7) Reimbursement for services of physicians and LLPs shall be subject to the global surgery policy as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services. The global surgery policy will not apply to the following codes:

(A) 59410–Vaginal delivery, including postpartum care.

(B) 59515–Caesarean delivery, including postpartum care.

(8) Reimbursement for services of physicians and LLPs shall be subject to the policy for supplies and services incident to other procedures as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services.

(9) Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and in intra-arterial injections, if it is used for patients who meet the criteria established by the office.

(10) Reimbursement for services of physicians and LLPs shall be subject to the site of service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the statewide fee schedule for physician and LLP services as established under subdivision (1). These procedures are identified using the site of service indicator on the Medicare fee schedule database.

(c) Reimbursement for services of NPPs shall be in accordance with the following:

(1) Reimbursement for services of dentists in calendar year 1994 shall be based on a statewide fee schedule equal to a percentage of the fiscal year 1992 submitted charges. That percentage shall be no lower than the average percentage difference between physician and LLP submitted charges and the fee established for those services in accordance with subsection (b)(1). The office may set reimbursement for specific dental procedures using a different methodology from that specified in this subdivision in order to preserve access to the service. Beginning with the effective date of this revised rule, fees for covered dental services are priced at the levels in effect at the end of calendar year 1994, increased by a percentage determined by the office.

(2) Reimbursement for services of:

(A) social workers certified through the American Academy of Certified Social Workers (ACSW) or who have masters of social work (MSW) degrees;

(B) psychologists with basic certificates; and

(C) licensed psychologists;

providing outpatient mental health services in a physician-directed outpatient mental health facility in accordance with 405 IAC 1-6-13 *[405 IAC 1-6 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]* and 405 IAC 1-7-20 *[405 IAC 1-7 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]* shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must continue to be billed through a physician or a physician-directed outpatient mental health facility.

(3) Reimbursement for services provided by independently practicing respiratory therapists and advance practice nurses shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1).

(4) Reimbursement for services of all other NPPs shall be equal to the statewide fee schedule for physician and LLP services as established under subsection (b)(1).

(d) The established rates for physician, LLP, and NPP reimbursement shall be reviewed annually by the office and adjusted as necessary.

(e) The relative value units used for the Indiana resource-based relative value scale fee schedule will be reviewed annually, taking into account the Medicare fee schedule proposed by the Health Care Financing Administration to take effect January 1 of the following calendar year and adjusted as necessary. *(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-2; filed Sep 6, 1994, 3:25 p.m.: 18 IR 88; errata filed Oct 18, 1994, 3:25 p.m.: 18 IR 532; filed Jun 21, 1995, 4:00 p.m.: 18 IR 2767; errata filed Sep 29, 1995, 1:30 p.m.: 19 IR 209; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-11.5-3 Additional provisions

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

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

(b) In the event that the provider is dissatisfied with rates issued in accordance with this section and has exhausted all interim review procedures provided in this article, it may seek an administrative appeal under IC 4-21.5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-3; filed Sep 6, 1994, 3:25 p.m.: 18 IR 89; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 12. Rate-Setting Criteria for Nonstate-Owned Intermediate Care Facilities for the Mentally Retarded and Community Residential Facilities for the Developmentally Disabled

405 IAC 1-12-1 Policy; scope

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; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified intermediate care facilities for the mentally retarded (ICF/MR), with the exception of those facilities operated by the state, and community residential facilities for the developmentally disabled (CRF/DD). Reimbursement for facilities operated by the state is governed by 405 IAC 1-4. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

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

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

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

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process.

(e) Providers must pay interest on all overpayments. The interest charge shall not exceed the percentage set out in IC 24-4.6-1-101. The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-1; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-2 Definitions

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

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

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

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

(e) "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be computed on a statewide basis for like levels of care, with the exception noted in this subsection, and shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1. If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8½) or fewer hours per patient day of actual staffing. If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs. If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental increased by one hundred fifty-nine percent (159%).

(f) "Change of provider status" means a bona fide sale or capital lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties. The term does not include a facility lease transaction that does not constitute a capital lease under Financial Accounting Standards Board Statement 13 as issued by the American Institute of Certified Public Accountants in November 1976.

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

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

(i) "DDARS" means the Indiana division of disability, aging, and rehabilitative services.

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

(k) "Desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

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

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

(n) "Forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

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

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

(q) "ICF/MR" means an intermediate care facility for the mentally retarded.

(r) "Like levels of care" means:

(1) care within the same level of licensure provided in a CRF/DD; or

(2) care provided in a nonstate-operated ICF/MR.

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

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

(u) "Patient or resident/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

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

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

(x) "Related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies.

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

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

(aa) "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-2; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; filed Aug 15, 1997, 8:47 a.m.: 21 IR 76; filed Oct 31, 1997, 8:45 a.m.: 21 IR 949; filed Aug 14, 1998, 4:27 p.m.: 22 IR 63; errata filed Dec 14, 1998, 11:37 a.m.: 22 IR 1526; filed Sep 3, 1999, 4:35 p.m.: 23 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3121)*

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

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

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider status transactions, unless otherwise prescribed by this rule.

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

(c) In the event that a field audit indicates that the provider's records are inadequate to support data submitted to the office and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this rule.

(d) Each provider shall submit, upon request by the office, confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.

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

(f) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the

central office is providing services related to patient or resident care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient or resident related lies with the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-3; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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

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

(1) Patient or resident census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income.

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

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and on the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that the data are true, accurate, related to patient or resident care, and that expenses not related to patient or resident care have been clearly identified.

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

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office or its representatives circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office or its representatives prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office or its representatives shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office or its representatives.

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost as a result of this penalty cannot be recovered by the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-4; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; filed Aug 14, 1998, 4:27 p.m.: 22 IR 64; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

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

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

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office

on or before thirty (30) days after notification of the certification date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:

(1) the prior provider's then current rate, if applicable; or

(2) the fiftieth percentile rates as computed in this subsection.

Initial interim rates shall be effective upon the later of the certification date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and ICF/MR providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the fiftieth percentile rates for developmental training homes shall be computed on a statewide basis using current rates of all basic developmental homes with eight and one-half (8½) or fewer hours per patient day of actual staffing. If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the fiftieth percentile rate for small behavior management residences for children shall be the fiftieth percentile rate for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs. If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the fiftieth percentile rate for small extensive medical needs residences for adults shall be the fiftieth percentile rate for basic developmental increased by one hundred fifty-nine percent (159%).

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

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

(1) Patient or resident census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income.

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

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined in this rule; private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

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

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

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

(e) The base rate may be in effect for longer or shorter than twelve (12) months. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the basis for the computation.

(f) The base rate established from the nine (9) months of historical data shall be the rate used for determining subsequent limitations on annual rate adjustments.

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

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

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

(j) The change of provider status shall be rescinded if subsequent transactions by the provider cause a capital lease to be reclassified as an operating lease under the pronouncements adopted in November 1976 by the American Institute of Certified Public Accountants. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-5; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2317; filed Aug 21, 1996, 2:00 p.m.: 20 IR 12; filed Aug 15, 1997, 8:47 a.m.: 21 IR 78; filed Oct 31, 1997, 8:45 a.m.: 21 IR 950; filed Sep 3, 1999, 4:35 p.m.: 23 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3123)*

405 IAC 1-12-6 Active providers; rate review; annual request; additional requests; requests due to change in law; request concerning capital return factor; computation of factor

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. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) A provider shall not be granted an additional rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional rate review during its rate effective year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical data. This additional rate review shall be completed in the same manner as the annual rate review, using all other limitations in effect at the time the annual review took place.

(c) To request the additional review, the provider shall submit, on forms prescribed by the office, a minimum of six (6) months of historical data, of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. Any new rate resulting from this additional review shall be effective on the first day of the month following the submission of data to the office.

(d) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office and will not be considered as an additional rate review.

(e) When changes to historical costs meet the requirements of section 5 of this rule, this section, and section 7 of this rule and amount to five percent (5%) or more of the historical cost of the facilities and equipment as reported on the most recent annual or historical report, the provider may request a rate review to establish a new basis for computation of the capital return factor portion of the rate. The change in the capital return factor shall be allowed subject to the maximum allowable annual rate increase limitation, adjusted by the difference between the capital return factor allowed before the change and the capital return factor allowed after the change. The capital return factor allowed after the change shall be computed using the actual occupancy level for existing beds, plus, where appropriate, those added census days needed to project the census in the additional beds in the following manner:

(1) For large ICFs/MR, the greater of:
    (A) ninety-five percent (95%) of total beds available; or
    (B) the occupancy the provider could reasonably anticipate for the additional beds.
(2) For CRFs/DD, the greater of:
    (A) ninety percent (90%) of total beds available; or
    (B) the occupancy the provider could reasonably anticipate for the additional beds.

In no event shall the occupancy used to calculate the capital return factor be less than ninety-five percent (95%) of total beds available for large ICFs/MR and ninety percent (90%) for CRFs/DD. Rate reviews completed under this section will not constitute the provider's additional rate review in one (1) reporting year. This review shall be completed in the same manner as the annual rate review, using all limitations in effect at the time the annual review or base rate review took place, whichever is later. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-6; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2318; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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. 7. (a) Rate setting shall be prospective, based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs, each provider's costs from the most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For purposes of determining the average allowable cost of the median patient day, each provider's costs from their most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint prescribed as follows:

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

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

(1) Director of nursing wages.
(2) Administrator wages.
(3) All costs reported in the ownership cost center, except repairs and maintenance.
(4) The capital return factor determined in accordance with sections 12 through 17 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-7; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; filed Sep 3, 1999, 4:35 p.m.: 23 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-12-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

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) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient or resident utilization.

(b) Each facility and home office shall be allowed:

(1) one (1) patient or resident care-related automobile; and
(2) one (1) vehicle that can be utilized for facility maintenance or patient or resident support or for both uses;

to be included in the vehicle basis for purposes of cost reimbursement under this rule. Vehicle basis means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for all allowable vehicles. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-8; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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. The Medicaid reimbursement system is based on recognition of the provider's allowable costs plus a potential profit add-on payment. The payment rate is subject to several limitations. Rates will be established at the lowest of the four (4) limitations listed as follows:

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

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

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

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

TABLE I

Profit Add-On

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

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

TABLE II

Overall Rate Limit

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-9; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2320; filed Aug 15, 1997,

8:47 a.m.: 21 IR 79; filed Oct 31, 1997, 8:45 a.m.: 21 IR 951; filed Aug 14, 1998, 4:27 p.m.: 22 IR 65; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124)

405 IAC 1-12-10 Computation of rate; allowable costs; review of cost reasonableness

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. (a) The per diem rate shall be an all-inclusive rate. The office shall not set a rate for more than one (1) level of care for each CRF/DD provider.

(b) Costs and revenues shall be reported as required on the financial report forms. Patient or resident care costs shall be clearly identified.

(c) The provider shall report as patient or resident care costs only costs that have been incurred in the providing of patient or resident care services. The provider shall certify on all financial reports that costs not related to patient or resident care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care throughout the state. The office may request satisfactory documentation from providers whose costs do not appear to be accurate and allowable.

(e) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-10; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-11 Allowable costs; services provided by parties related to provider

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. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.
(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to this subsection may be granted by the office if requested in writing by the provider before the rate effective date of the review to which the exception is to apply.

(e) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.

(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other

organizations and are not a basic element of patient or resident care ordinarily furnished directly to patients or residents by such institutions.

(4) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-11; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-12-12 Allowable costs; capital return factor

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. 12. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient or resident care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The capital return factor portion of the established rate is the sum of the allowed use fee, return on equity, and rent payments.

(c) Allowable patient or resident care-related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-12; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-13 Allowable costs; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties

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. (a) The use fee limitation is based on the following:

(1) The assumption that facilities and equipment are prudently acquired and financed.

(2) Providers will obtain independent financing in accordance with a sound financial plan.

(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years.

(c) The use fee component of the capital return factor shall be limited by the lesser of:

(1) the original loan balance at the time of acquisition;

(2) eighty percent (80%) of historical cost of the facilities and equipment; or

(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization

period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall be recognized only when the interest rate is less than the original financing, and the interest rate on the refinancing shall not be allowable in excess of the interest rate limit established on the date the refinancing commitment was signed and the interest rate fixed by the lender and borrower.

(g) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (f).

(h) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(i) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of actual revenues. Interest on such loans shall be recognized only if the provider can demonstrate that such loans were reasonable and necessary in providing patient or resident related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(j) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than patient or resident care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(k) Loans from a related party must be identified and reported separately on the annual or historical financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid in accordance with an established repayment schedule.

(l) Use fee for variable interest rate mortgages will be calculated as follows:

(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.

(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).

(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.

(4) The use fee on the prospective rate is the amount determined in subdivision (3) plus or minus the variance in subdivision (2).

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-13; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2322; filed Sep 1, 2000, 2:10 p.m.: 24 IR 16; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-12-14 Allowable costs; capital return factor; computation of return on equity component

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. 14. (a) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

before the effective date of this rule, the return on equity shall be computed on the higher of twenty percent (20%) of the allowable historical cost of facilities and equipment or actual equity in allowable facilities and equipment up to sixty percent (60%) of allowable historical cost of facilities and equipment. Allowable historical cost of facilities and equipment is the lesser of the provider's actual historical costs of facilities and equipment, or the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum allowable property basis per bed on the rate effective date.

(b) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one

percent (1%) below the United States Treasury bond, thirty (30) year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

(d) The return on equity determined under this section shall be subject to the limitations of section 15(b) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-14; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2323; filed Sep 1, 2000, 2:10 p.m.: 24 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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

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

The maximum property basis per bed at the time of acquisition shall be in accordance with the following schedule:

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

9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700

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

(b) The capital return factor portion of a rate that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on:

(A) the maximum property basis per bed at the time of acquisition of each bed, plus one-half (½) of the difference between that amount and the maximum property basis per bed at the rate effective date;

(B) the term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983; and

(C) the allowable interest rate is the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on:

(A) the allowable equity as established under section 14 of this rule; and

(B) the rate of return on equity is the greater of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be no greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Indiana Medicaid program shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.

(3) Travel costs.

(4) The costs of feasibility studies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-15; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2324; filed Sep 1, 2000, 2:10 p.m.: 24 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-12-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation

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. 16. (a) The basis used in computing the capital return factor shall be the historical cost of all assets used to deliver patient or resident related services, provided the following:

(1) They are in use.

(2) They are identifiable to patient or resident care.

(3) They are available for physical inspection.

(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the capital return factor.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual or historical financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the capital return factor shall include only items currently used in providing services customarily provided to patients or residents.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-16; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2325; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members

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. 17. (a) If a facility is sold or leased within eight (8) years of the seller's or lessor's acquisition date and this transaction is recognized as a change of provider status, the buyer's or lessee's property basis in facilities and equipment shall be the seller's or lessor's historical cost basis plus one percent (1%) of the difference between the purchase price, or appraised value if lower, and the seller's or lessor's historical cost basis, for each month the seller or lessor has owned or leased the property.

(b) Leases shall be subject to the following purchase equivalency test based on the maximum capital return factor. The provider shall supply sufficient information to the office so as to determine the terms and conditions of a purchase that would be equivalent to the lease agreement. Such information shall include the following:

(1) Property basis and fair market value on the initial lease effective date.

(2) Inception date of the initial agreement between lessee and lessor.

(3) Imputed or stated interest rate.

(4) Duration of payments.

(5) Renewal options.

Such purchase equivalency terms and conditions shall be utilized to calculate the capital return factor as if it were a purchase. The provisions of section 15(c) through 15(d) of this rule shall apply. The lease payments determined under this section shall be subject to the limitations under section 15(b) of this rule.

(c) Where the imputed or stated interest rate is a variable rate, it shall be recognized only if the rate is reasonable and only if such arrangement was incorporated into the lease agreement at the time of acquisition.

(d) All leases, rental agreements, and contracts involving the use of property shall be subject to the same limitations as owners

of property. The use fee calculation for variable rate leases will be calculated in the same manner as that set forth in section 13(k) of this rule. In no event shall the capital return factor be greater than the actual lease payment.

(e) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the capital return factor except as described in this section for the sale of facilities between family members.

(f) The sale of facilities between family members shall be eligible for consideration as a change of provider status transaction if all of the following requirements are met:

(1) There is no spousal relationship between parties.

(2) The following persons are considered family members:

(A) Natural parents, child, and sibling.

(B) Adopted child and adoptive parent.

(C) Stepparent, stepchild, stepsister, and stepbrother.

(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, and daughter-in-law.

(E) Grandparent and grandchild.

(3) The provider can demonstrate to the satisfaction of the office that the primary business purpose for the sale is other than increasing the established rate.

(4) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.

(5) The seller is not associated with the facility in any way after the sale other than as a passive creditor.

(6) The buyer is actively engaged in the operation of the facility after the sale with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.

(7) This family sale exception has not been utilized during the previous eight (8) years on this facility.

(8) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.

(9) If any of the entities involved are corporations, they must be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.

(g) In order to establish an historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis shall be the lower of the historical cost basis of the buyer or ninety percent (90%) of the MAI appraisal of facilities and equipment.

(h) If the conditions of this section are met, the cost basis and financing arrangements of the facility shall be recognized for the purpose of computing the capital return factor in accordance with this rule for a bona fide sale arising from an arm's-length transaction.

(i) If a lease of facilities between family members under subsection (f)(2) qualifies as a capitalized lease under guidelines issued in November 1976 by the American Institute of Certified Public Accountants, the transaction shall be treated as a sale of facilities between family members, for purposes of determining the basis, cost, and valuation of the buyer's capital return factor component of the Medicaid rate. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-17; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2325; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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. 18. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual or historical financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients or nonresidents shall be offset against the total cost of such service to determine the allowable patient or resident related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-18; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2326; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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

(b) The provider shall report using the forms or in a format prescribed by the office all patient and resident related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by employees. If a service is performed through a contractual agreement, imputed hours for contracted services are only required when such services obviate the need for staffing of a major function or department that is normally staffed by in-house personnel. Hours for laundry services in CRF/DD or ICF/MR facilities that are properly documented through appropriate time studies, whether paid in-house or contracted, shall not be included in calculating the staffing limitation for the facility. Hours associated with the provision of day services and other ancillary services shall be excluded from the staffing limitation.

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

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owners or related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owners or related parties is not subject to the limitation found in section 20 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-19; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

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. 20. (a) Compensation for owner, related party, individuals within management, consultants who perform management functions, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, individuals within management, contractors, and consultants who perform management functions, as well as any other individual or entity performing such tasks.

(b) The maximum amount of owner, related party, management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (d), as updated by the office on July 1 of each year by determining the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient or resident related wages, salaries, or fees actually paid or withdrawn which were properly reported to the Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) In addition to wages, salaries, and fees paid to owners under subsection (b), the office will allow up to twelve percent (12%) of the appropriate schedule for fringe benefits, business expenses charged to an operation, and other assets actually withdrawn that are patient or resident related. These expenses include fringe benefits that do not meet nondiscriminatory requirements of the Internal Revenue Code, entertainment, travel, or continuing education. Other assets actually withdrawn include only those items that were actually accrued and subsequently paid during the cost reporting period in which personal services were rendered and reported to the Internal Revenue Service as fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within

seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(d) The owner, related party, and management compensation and expense limitation per operation effective July 1, 1993, shall be as follows:

Owner and Management Compensation		Owner's Expense
Beds	Allowance	(12% × bed allowance)
10	$18,527	$2,223
20	$24,717	$2,966
30	$30,887	$3,706
40	$37,049	$4,446
50	$43,241	$5,189
60	$46,948	$5,634
70	$50,657	$6,079
80	$54,362	$6,523
90	$58,055	$6,967
100	$61,763	$7,412
110	$66,731	$8,007
120	$71,663	$8,600
130	$76,628	$9,195
140	$81,546	$9,786
150	$86,496	$10,380
160	$91,427	$10,971
170	$96,378	$11,565
180	$101,313	$12,157
190	$106,262	$12,751
200	$111,196	$13,343
200 and over	$111,196 plus $225 per bed over 200	$13,343 plus $27 per bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-20; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-21 Nonstate-operated intermediate care facilities for the mentally retarded; allowable costs; compensation; per diem rate

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

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

(c) Costs related to staffing shall be limited to seven (7) hours worked per patient day. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-21; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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. 22. (a) Notwithstanding the application of standards and procedures set forth in sections 1 through 20 of this rule, the procedures described in this section apply to intermediate care facilities for the mentally retarded with eight (8) or fewer beds (community residential facilities for the developmentally disabled), except for intermediate care facilities for the mentally retarded licensed as:

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

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

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

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

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

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

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

(d) The per diem rate shall be an all-inclusive rate. The established rate includes all services provided to residents by a facility. The office shall not set a rate for more than one (1) level of care for each community residential facility for the developmentally disabled provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-22; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; filed Aug 15, 1997, 8:47 a.m.: 21 IR 81; filed Oct 31, 1997, 8:45 a.m.: 21 IR 953; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124)*

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

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. 23. (a) Routine and nonroutine medical supplies and equipment are included in the provider's approved per diem rate, and the provider shall not bill the Medicaid program for such items in addition to the established rate. Under no circumstances shall

the routine and nonroutine medical supplies and equipment be billed through a pharmacy or other provider. Routine supplies and equipment include those items routinely required for the care of residents. Nonroutine medical supplies and equipment are those items for which the need must be demonstrated by the resident's particular condition and identifiable to that resident. The medical records of each resident must indicate, by specific written physician's orders, the order for the service or supply furnished and the dispensing of the service or supply to the resident.

(b) Personal care or comfort items include the following:

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

These items may be included in the approved room charge. Under no circumstances shall items included as personal care or comfort be billed through a pharmacy or other provider to the Medicaid program. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-23; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-24 Assessment methodology

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-32-11

Sec. 24. (a) CRF/DD and ICF/MR facilities that are not operated by the state will be assessed an amount not to exceed ten percent (10%) of the gross residential services revenue of the facility for the facility's annual reporting period year for annual rate reviews. CRF/DD and ICF/MR facilities that are not operated by the state will be assessed an amount not to exceed ten percent (10%) of the annualized gross residential services revenue of the facility for the facility's preceding nine (9) months for determining the base rate as set out in section 5(d) of this rule. The assessment percentage shall be determined annually by the office or its contractor in such a manner that the amount assessed shall, in the aggregate, not exceed six percent (6%) of total facility revenues.

(b) The assessment on provider gross residential services revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Gross residential services revenue is defined as revenue from the provider's previous reporting period as set out in section 4(a) of this rule or previous base rate reporting period set out in section 5(d) of this rule and excludes allowable day services costs for the period. Providers will submit data to calculate the amount of provider assessment with their annual base and rate reviews as set out in sections 4(a) and 5(d) of this rule, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(c) If federal financial participation to match the assessment becomes unavailable under federal law after the implementation date, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes place, and such termination will apply prospectively. In addition, prospective termination of the assessment as described in this subsection will result in the simultaneous termination of the assessment being considered as an allowable cost for rate setting purposes. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-24; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; filed Aug 14, 1998, 4:27 p.m.: 22 IR 67; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:40 a.m.: 25 IR 381)*

405 IAC 1-12-25 Reimbursement for day services

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. 25. For CRF/DD facilities the all-inclusive per diem rate shall include reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate setting purposes in accordance with all sections of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-25; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2330; filed Aug 14, 1998, 4:27 p.m.: 22 IR 68; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-12-26 Administrative reconsideration; appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5; IC 12-13-7-3

Sec. 26. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

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

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under IC 4-21.5.

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-26; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 13. Disproportionate Share Hospital Payments

405 IAC 1-13-1 Eligibility

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

Sec. 1. (a) Eligibility for basic and enhanced disproportionate share hospital payments for hospital providers that are not owned or operated by the state will be determined using a provider's Medicaid inpatient utilization rate and low income utilization rate based on utilization and revenue data from the cost reporting period used to determine that provider's eligibility for disproportionate share payments as of July 1, 1992.

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

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

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

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-13-1; filed Jan 27, 1994, 5:00 p.m.: 17 IR 1090; filed May 25, 1995, 3:00 p.m.: 18 IR 2409; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-13-2 Basic disproportionate share payments

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

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

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

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-13-2; filed Jan 27, 1994, 5:00 p.m.: 17 IR 1090; filed May 25, 1995, 3:00 p.m.: 18 IR 2409; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Rule 14. Rate-Setting Criteria for Nursing Facilities (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Dec 27, 1994, 3:45 p.m.: 18 IR 1260)

Rule 14.1. Rate-Setting Criteria for Nursing Facilities (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed May 30, 1997, 4:25 p.m.: 20 IR 2774)

Rule 14.2. Rate-Setting Criteria for Nursing Facilities (Voided)

NOTE: Voided by P.L.130-1998, SECTION 3, retroactively effective July 1, 1997.

Rule 14.5. Rate-Setting Criteria for HIV Nursing Facilities

405 IAC 1-14.5-1 Policy; scope

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; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified nursing facilities (NF) that provide skilled and intermediate nursing care for chronically medically dependent people infected by the human immunodeficiency virus (HIV). All payments referred to within this rule for the provider group and levels of care are contingent upon the following:

(1) Proper and current certification.

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

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs

which must be incurred by efficiently and economically operated facilities. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-1; filed Aug 12, 1998, 2:32 p.m.: 22 IR 48; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-2 Definitions

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. (a) As used in this rule, "allowable per patient day cost" means a ratio between total allowable cost and patient days.

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

(c) As used in this rule, the "Medicaid cost per patient day" means the sum of the direct care, indirect care, administrative and capital component medians calculated in accordance with 405 IAC 1-14.3 *[sic.]*. For providers of skilled nursing care for chronically medically dependent persons infected with the human immunodeficiency virus (HIV), the Medicaid cost per patient day is calculated by adding:

(1) the product of the direct care median times a Medicaid case mix level of 1.27;
(2) the indirect care median;
(3) the administrative median; and
(4) the capital component median.

For providers of intermediate nursing care for chronically medically dependent persons infected with the human immunodeficiency virus (HIV), the Medicaid cost per patient day is calculated by adding:

(1) the product of the direct care median times a Medicaid case mix level of .69;
(2) the indirect care median;
(3) the administrative median; and
(4) the capital component median.

The Medicaid cost per patient day shall be computed on a statewide basis and shall be maintained by the office with revisions made four (4) times per year effective April 1, July 1, October 1, and January 1.

(d) As used in this rule, "change of provider status" means a bona fide sale or capital lease that, for reimbursement purposes, is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties. The term does not include a facility lease transaction that does not constitute a capital lease under Financial Accounting Standards Board Statement 13 as issued by the American Institute of Certified Public Accountants in November 1976.

(e) As used in this rule, "chronically medically dependent" means a medical condition of a person who is infected by the human immunodeficiency virus (HIV) and has been certified by a physician as, because of the HIV infection, requiring a skilled or intermediate level of care as specified under 405 IAC 1-3-1 and 1-3-2 *[sic., 405 IAC 1-3-2]*.

(f) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(g) As used in this rule, "debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

(h) As used in this rule, "desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

(i) As used in this rule, "equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year end.

(j) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(k) As used in this rule, "forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(l) As used in this rule, "general line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(m) As used in this rule, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(n) As used in this rule, "like levels of care" means:

(1) skilled care provided in a nursing facility;

(2) intermediate care provided in a nursing facility;

(3) special skilled or intermediate services provided to persons who are chronically medically dependent because of HIV.

(o) As used in this rule, "medical and nonmedical supplies and equipment" include those items generally required to assure adequate medical care and personal hygiene of patients by providers of like levels of care.

(p) As used in this rule, "office" means the office of Medicaid policy and planning.

(q) As used in this rule, "ordinary patient related costs" means costs of services and supplies that are necessary in delivery of patient care by similar providers within the state.

(r) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(s) As used in this rule, "profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

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

(u) As used in this rule, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies.

(v) As used in this rule, "special skilled or intermediate services" means medical and health care services that are provided to a patient who is:

(1) chronically medically dependent; and

(2) in need of a level of care that is less intensive than the care provided in a hospital licensed under IC 16-10-1 *[IC 16-10 was repealed by P.L.2-1993, SECTION 209, effective April 30, 1993.]*.

(w) As used in this rule, "unit of service" means all patient care at the appropriate level of care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(x) As used in this rule, "use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-2; filed Aug 12, 1998, 2:32 p.m.: 22 IR 49; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

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) Generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider status transactions unless otherwise prescribed by this rule.

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

(c) In the event that a field audit indicates that the provider's records are inadequate to support data submitted to the office and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are

corrected and notice is sent to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this rule.

(d) Each provider shall submit, upon request, confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.

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

(f) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient related lies with the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-3; filed Aug 12, 1998, 2:32 p.m.: 22 IR 50; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

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

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

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

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

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

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

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

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

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

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

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

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-4; filed Aug 12, 1998, 2:32 p.m.: 22 IR 51; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.5-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

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. 5. (a) Rate requests to establish initial interim rates for a new operation or a new type of certified service, or for a change of provider status, shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service. Initial interim rates will be set at the greater of the prior provider's then current rate, if applicable, or the fiftieth percentile rate. Initial interim rates shall be effective upon certification or the date that a service is established, whichever is later. The fiftieth percentile shall be computed on a statewide basis for like levels of care using current rates of all nursing facility providers. The fiftieth percentile rate shall be maintained by the office, and a revision shall be made to this rate four (4) times per year effective on March 1, June 1, September 1, and December 1.

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

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

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

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

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

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

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

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

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

(d) The base rate may be in effect for longer or shorter than twelve (12) months. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the

basis for the computation.

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

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

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

(h) The change of provider status shall be rescinded if subsequent transactions by the provider cause a capital lease to be reclassified as an operating lease under the pronouncements adopted by the American Institute of Certified Public Accountants. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-5; filed Aug 12, 1998, 2:32 p.m.: 22 IR 51; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-6 Active providers; rate review; annual request; additional requests; requests due to change in law; requests concerning capital return factor; computation of factor

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. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office.

(c) When changes to historical costs meet the requirements of section 5 of this rule, this section, and section 7 of this rule and amount to five percent (5%) or more of the historical cost of the facilities and equipment as reported on the most recent annual or historical report, the provider may request a rate review to establish a new basis for computation of the capital return factor portion of the rate. The change in the capital return factor shall be allowed subject to the difference between the capital return factor allowed before the change and the capital return factor allowed after the change. The capital return factor allowed after the change shall be computed using minimum occupancy levels specified in section 7(b) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-6; filed Aug 12, 1998, 2:32 p.m.: 22 IR 52; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-7 Request for rate review; occupancy level assumptions; effect of inflation

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. 7. (a) Rate setting shall be prospective, based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For nursing facilities, allowable costs per patient day for certain fixed costs shall be determined based on an occupancy level equal to the greater of ninety percent (90%) effective with the effective date of this rule or actual occupancy. The fixed costs subject to this minimum occupancy level standard include the capital return factor determined in accordance with sections 12 through 17 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-7; filed Aug 12, 1998, 2:32 p.m.:*

22 IR 53; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.5-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

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) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient utilization.

(b) Each facility and home office shall be allowed only one (1) patient care-related automobile to be included in the vehicle basis for purposes of cost reimbursement under this rule. As used in this subsection, "vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-8; filed Aug 12, 1998, 2:32 p.m.: 22 IR 53; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-9 Criteria limiting rate adjustment granted by office

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) The Medicaid reimbursement system is based on recognition of the provider's allowable costs, plus a potential profit add-on payment. The payment rate is subject to several limitations. Rates will be established at the lowest of the four (4) limitations listed as follows:

(1) The Medicaid cost per patient day times one hundred fifteen percent (115%). This subdivision does not apply to private room rates.

(2) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services.

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

(4) Inflated allowable per patient day cost plus the allowed profit add-on payment. The profit add-on is equal to fifty percent (50%) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient day cost, and one hundred ten percent (110%) of the Medicaid cost per patient day, calculated on a statewide basis. Under no circumstances shall a provider's profit add-on exceed ten percent (10%) of the Medicaid cost per patient day, calculated on a statewide basis.

(b) The rate for private rooms and the rate for rooms with three (3) beds or more shall be calculated using the ratio or percentage spread of the proposed private pay rates for those types of beds times the rate for rooms with two (2) beds, subject to the other limitations of this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-9; filed Aug 12, 1998, 2:32 p.m.: 22 IR 53; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-10 Computation of rate; allowable costs; review of cost reasonableness

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. (a) Costs and revenues shall be reported as required on the financial report forms. Patient care costs shall be clearly identified.

(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care throughout the state. The office may request satisfactory documentation from providers whose costs do not appear

to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-10; filed Aug 12, 1998, 2:32 p.m.: 22 IR 53; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-11 Allowable costs; services provided by parties related to provider

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. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.
(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to this subsection may be granted by the office if requested in writing by the provider before the rate effective date of the review to which the exception is to apply.

(e) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization.
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.
(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-11; filed Aug 12, 1998, 2:32 p.m.: 22 IR 54; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.5-12 Allowable costs; capital return factor

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. 12. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land, and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The capital return factor portion of the established rate is the sum of the allowed use fee, return on equity, and rent payments.

(c) Allowable patient care-related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-12; filed Aug 12, 1998, 2:32 p.m.: 22 IR 54; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-13 Allowable costs; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties

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. (a) The use fee limitation is based on the following:

(1) The assumption that facilities and equipment are prudently acquired and financed.

(2) Providers will obtain independent financing in accordance with a sound financial plan.

(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years.

(c) The use fee component of the capital return factor shall be limited by the lesser of:

(1) the original loan balance at the time of acquisition;

(2) eighty percent (80%) of historical cost of the facilities and equipment; or

(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall only be recognized when the interest rate is less than the original financing, and the interest rate on the refinancing shall not be allowable in excess of the interest rate limit established on the date the refinancing commitment was signed and the interest rate fixed by the lender and borrower.

(g) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (f).

(h) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(i) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of actual revenues. Interest on such loans shall only be recognized if the provider can demonstrate that such loans were reasonable and necessary in providing patient related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(j) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than patient care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(k) Loans from a related party must be identified and reported separately on the annual or historical financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and

such loans are repaid in accordance with an established repayment schedule.

(l) Use fee for variable interest rate mortgages will be calculated as follows:

(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.

(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).

(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.

(4) The use fee on the prospective rate is the amount determined in subdivision (3) plus or minus the variance in subdivision (2).

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-13; filed Aug 12, 1998, 2:32 p.m.: 22 IR 55; filed Sep 1, 2000, 2:10 p.m.: 24 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.5-14 Allowable costs; capital return factor; computation of return on equity component

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. 14. (a) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

before the effective date of this rule, the return on equity shall be computed on the higher of twenty percent (20%) of the allowable historical cost of facilities and equipment, or actual equity in allowable facilities and equipment. Allowable historical cost of facilities and equipment is the lesser of the provider's actual historical cost of facilities and equipment or the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum allowable property basis per bed on the rate effective date.

(b) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the United States Treasury bond, thirty (30) year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

(d) The return on equity determined under this section shall be subject to the limitations under section 15(b) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-14; filed Aug 12, 1998, 2:32 p.m.: 22 IR 56; filed Sep 1, 2000, 2:10 p.m.: 24 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.5-15 Allowable costs; capital return factor; use fee; depreciable life; property basis

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

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

The maximum property basis per bed at the time of acquisition shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080
10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500
3/1/87	$21,900
9/1/87	$22,400
3/1/88	$22,600
9/1/88	$23,000
3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700
3/1/94	$26,000
9/1/94	$26,300
3/1/95	$26,500
9/1/95	$27,300
3/1/96	$27,700
9/1/96	$28,000
3/1/97	$28,300
9/1/97	$28,600

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

(b) The capital return factor portion of a rate that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on:

(A) the maximum property basis per bed at the time of acquisition of each bed, plus one-half (½) of the difference between that amount and the maximum property basis per bed at the rate effective date times eighty percent (80%);

(B) the term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983; and

(C) the allowable interest rate is the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on:

(A) the allowable equity as established under section 14 of this rule; and

(B) a rate of return on equity that is the greater of United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be no greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Indiana Medicaid program shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.

(3) Travel costs.

(4) The costs of feasibility studies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-15; filed Aug 12, 1998, 2:32 p.m.: 22 IR 56; filed Sep 1, 2000, 2:10 p.m.: 24 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.5-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation

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. 16. (a) The basis used in computing the capital return factor shall be the historical cost of all assets used to deliver patient related services, provided the following:

(1) They are in use.

(2) They are identifiable to patient care.

(3) They are available for physical inspection.

(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the capital return factor.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual or historical financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the capital return factor shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and an *[sic., a]* historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-16; filed Aug 12, 1998, 2:32 p.m.: 22 IR 57; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members

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. 17. (a) If a facility is sold or leased within eight (8) years of the seller's/lessor's acquisition date, and this transaction is recognized as a change of provider status, the buyer's/lessee's property basis in facilities and equipment shall be the seller's/lessor's historical cost basis plus one percent (1%) of the difference between the purchase price, or appraised value if lower, and the seller's/lessor's historical cost basis for each month the seller/lessor has owned/leased the property.

(b) Leases shall be subject to the following purchase equivalency test based on the maximum capital return factor. The provider shall supply sufficient information to the office so as to determine the terms and conditions of a purchase that would be equivalent to the lease agreement. Such information shall include the following:

(1) Property basis and fair market value on the initial lease effective date.
(2) Inception date of the initial agreement between lessee and lessor.
(3) Imputed or stated interest rate.
(4) Duration of payments.
(5) Renewal options.

Such purchase equivalency terms and conditions shall be utilized to calculate the capital return factor as if it were a purchase. The provisions of section 15(c) through 15(d) of this rule shall apply. The lease payments determined under this section shall be subject to the limitations under section 15(b) of this rule.

(c) Where the imputed or stated interest rate is a variable rate, it shall be recognized provided the rate is reasonable and only if such arrangement was incorporated into the lease agreement at the time of acquisition.

(d) All leases, rental agreements, and contracts involving the use of property shall be subject to the same limitations as owners of property. The use fee calculation for variable rate leases will be calculated in the same manner as that set forth in section 13(k) of this rule. In no event shall the capital return factor be greater than the actual lease payment.

(e) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the capital return factor except as described in this section for the sale of facilities between family members.

(f) The sale of facilities between family members shall be eligible for consideration as a change of provider status transaction if all of the following requirements are met:

(1) There is no spousal relationship between parties.
(2) The following persons are considered family members:
    (A) Natural parent, child, and sibling.
    (B) Adopted child and adoptive parent.

(C) Stepparent, stepchild, stepsister, and stepbrother.

(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.

(E) Grandparent and grandchild.

(3) The provider can demonstrate to the satisfaction of the office that the primary business purpose for the sale is other than increasing the established rate.

(4) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.

(5) The seller is not associated with the facility in any way after the sale other than as a passive creditor.

(6) The buyer is actively engaged in the operation of the facility after the sale with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.

(7) This family sale exception has not been utilized during the previous eight (8) years on this facility.

(8) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.

(9) If any of the entities involved are corporations, they must be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.

(g) In order to establish an *[sic., a]* historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis shall be the lower of the historical cost basis of the buyer or ninety percent (90%) of the MAI appraisal of facilities and equipment.

(h) If the conditions of this section are met, the cost basis and financing arrangements of the facility shall be recognized for the purpose of computing the capital return factor in accordance with this rule for a bona fide sale arising from an arm's-length transaction.

(i) If a lease of facilities between family members under subsection (f)(2) qualifies as a capitalized lease under guidelines established by the American Institute of Certified Public Accountants, the transaction shall be treated as a sale of facilities between family members for purposes of determining the basis, cost, and valuation of the buyer's capital return factor component of the Medicaid rate. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-17; filed Aug 12, 1998, 2:32 p.m.: 22 IR 58; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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. 18. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual or historical financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-18; filed Aug 12, 1998, 2:32 p.m.: 22 IR 59; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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. 19. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided such employees are engaged in patient care-related functions and that compensation amounts are reasonable and allowable under this section and sections 20 through 26 of this rule.

(b) The provider shall report on the financial report form, in the manner prescribed using the forms prescribed by the office, all patient related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation

and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by personnel. If a service is performed through a contractual agreement, imputed hours for contracted services shall be reported. Hours for laundry and therapy services in nursing facilities, whether paid in-house or contracted, shall not be included in calculating the staffing limitation, but shall be reported on the financial report form using the forms or in the format prescribed by the office.

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

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owner/related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owner/related parties is not subject to the limitation found in section 20 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-19; filed Aug 12, 1998, 2:32 p.m.: 22 IR 59; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

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. 20. (a) Compensation for owner, related party, management, consultants who perform management functions, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks.

(b) The maximum amount of owner, related party, management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (d), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient related wages, salaries, or fees actually paid or withdrawn which were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) In addition to wages, salaries, and fees paid to owners under subsection (b), the office will allow up to twelve percent (12%) of the appropriate schedule for fringe benefits, business expenses charged to an operation, and other assets actually withdrawn that are patient related. These expenses include fringe benefits that do not meet nondiscriminatory requirements of the Internal Revenue Code, entertainment, travel, or continuing education. Other assets actually withdrawn include only those items that were actually accrued and subsequently paid during the cost reporting period in which personal services were rendered and reported to the federal Internal Revenue Service as fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(d) The owner, related party, and management compensation and expense limitation per operation effective July 1, 1997, shall be as follows:

Owner and Management Compensation		Owner's Expense
Beds	Allowance	(12% × Bed Allowance)
10	$22,500	$2,700
20	$30,019	$3,602
30	$37,513	$4,502
40	$44,998	$5,400

50	$52,517	$6,302
60	$57,019	$6,842
70	$61,524	$7,383
80	$66,023	$7,923
90	$70,510	$8,461
100	$75,013	$9,002
110	$81,046	$9,726
120	$87,037	$10,444
130	$93,066	$11,168
140	$99,040	$11,885
150	$105,052	$12,606
160	$111,040	$13,325
170	$117,054	$14,046
180	$123,048	$14,766
190	$129,058	$15,487
200	$135,050	$16,206
200 and over	$135,050 + $250/bed over 200	$16,206 + $30/bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-20; filed Aug 12, 1998, 2:32 p.m.: 22 IR 59; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-21 Staffing costs in nursing facilities

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. 21. Subject to the exclusions specified in section 19(b) of this rule, recognition of the costs related to total staffing requirements will be limited to five and one-half (5½) hours worked per patient day in nursing facilities providing skilled care and four and one-fourth (4¼) hours worked per patient day in nursing facilities providing intermediate care. Hours worked exclude vacation, sick, and holiday pay. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-21; filed Aug 12, 1998, 2:32 p.m.: 22 IR 60; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-22 Medical or nonmedical supplies and equipment

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. 22. The approved per diem rate in nursing facilities includes the cost of both medical and nonmedical supply items, and the provider shall not bill the Medicaid program for such items in addition to the established rate. Under no circumstances shall medical or nonmedical supplies and equipment be billed through a pharmacy or other provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-22; filed Aug 12, 1998, 2:32 p.m.: 22 IR 60; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-23 Nursing facilities providing intermediate and skilled care; reimbursement for therapy services

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. 23. (a) Therapy services provided to Medicaid recipients by nursing facilities providing intermediate care or skilled care

are to be included in the established rate. Under no circumstances shall therapies be billed to Medicaid through any provider. Services which may be reported in the cost report used to determine the established rate include the following:

(1) Audiology.

(2) Physical therapy.

(3) Speech therapy.

(4) Occupational therapy.

(5) Respiratory therapy.

All such services shall be provided and reimbursed only if they meet the conditions as prescribed in the Indiana Medicaid provider manual for nursing facilities providing intermediate care or skilled care.

(b) A nursing facility providing intermediate care or skilled care may elect to provide therapy services if either of the following conditions are met:

(1) The facility employs licensed/certified therapists as members of its staff.

(2) The facility has a contract with a licensed/certified therapist or therapy agency to provide services to residents of the facility.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-23; filed Aug 12, 1998, 2:32 p.m.: 22 IR 60; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.5-24 Nursing facilities providing intermediate care and skilled care; allocation of intermediate and skilled care costs

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. 24. (a) The detailed basis for allocation of expenses between different levels of care and special services (HIV) in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) However, the following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.

(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(3) Any change in the allocations must be approved by the department prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the department for approval at least ninety (90) days prior to the provider's reporting year end. If a change in allocation basis has not been approved by the department, the provider shall not submit cost reports using a new allocation basis.

(4) The allocation basis for the capital return factor calculated under sections 12 through 17 of this rule shall be patient days, unless a different allocation methodology was approved prior to October 1, 1990, and the provider has not changed the number of beds in either level of care since October 1, 1990. In those instances, the previously approved allocation methodology may be continued.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-24; filed Aug 12, 1998, 2:32 p.m.: 22 IR 61; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.5-25 Administrative reconsideration; appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15

Sec. 25. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within

forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

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

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under IC 4-21.5-3.

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process in accordance with section 1(d) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-25; filed Aug 12, 1998, 2:32 p.m.: 22 IR 61; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.5-26 Nursing facilities; separate add-on reimbursement for chronically medically dependent people infected by the human immunodeficiency virus

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. 26. (a) Care for a chronically medically dependent person may be reimbursed under this section to those providers of skilled or intermediate nursing services who provide the required level of care.

(b) Costs that are reimbursed under this rate must meet the following conditions:

(1) Be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care and services in conformity with applicable state and federal laws, rules, regulations, and quality and safety standards.

(2) Include, to the extent permitted by federal laws and regulations, increased costs for:

(A) respiratory therapy;
(B) intensive case management;
(C) medically-related social services;
(D) physician and nursing care;
(E) linens; and
(F) dietary supplements.

(c) Recognition of the costs related to total staffing will be limited to an overall staffing limit for all personnel of not more than eight (8) hours per patient day for skilled level of care, and not more than six (6) hours per patient day for intermediate level of care.

(d) No cost recognition will be included in the per diem for those services provided by a health care provider which are being separately reimbursed by the Medicaid program.

(e) Rate requests to establish initial interim rates for a new operation or a new type of certified service, or for a change of provider status, shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service. Initial interim rates will be set at the greater of the prior provider's then current rate, if applicable, or the fiftieth percentile rate. Initial interim rates shall be effective upon certification or the date a service is established, whichever is later. The fiftieth percentile shall be computed on a statewide basis for like levels of care using current rates of all nursing facility providers. The fiftieth percentile rate shall be maintained by the office, and a revision shall be made to this rate four (4) times per year effective on March 1, June 1, September 1, and December 1.

(f) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base

rate shall be effective from the first day of the tenth month of certified operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of the calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

(g) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation, and an extension had not been granted, the initial rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after receipt of the report by the office.

(h) Providers of special skilled and intermediate services licensed under IC 16-10-4 *[IC 16-10 was repealed by P.L.2-1993, SECTION 209, effective April 30,1993.]* that have been approved by the office must have more than eight (8) beds but less than forty (40) beds approved for this type of service. Bed allocation will be based upon locality and reasonableness on a first come first served basis.

(i) The office may not approve more than one hundred (100) beds for special skilled or intermediate services without the agreement of the secretary of Indiana family and social services administration, the commissioner of the Indiana state department of health, and the assistant secretary of the office.

(j) Allowable costs per patient day for certain fixed costs shall be determined based on an occupancy level equal to the greater of ninety percent (90%) effective with the effective date of this rule or actual occupancy based on beds available to the program. The fixed costs subject to this minimum occupancy level standard include the capital return factor determined in accordance with sections 12 through 17 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-26; filed Aug 12, 1998, 2:32 p.m.: 22 IR 62; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 14.6. Rate-Setting Criteria for Nursing Facilities

405 IAC 1-14.6-1 Policy; scope

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; IC 24-4.6-1-101

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

(1) Proper and current certification.

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

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

(c) Retroactive payment or repayment will be required when an audit verifies an underpayment or overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data, or resident assessment data which caused a lower or higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-1; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-2 Definitions

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. (a) As used in this rule, "administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including directors fees) for patient-related services.

(2) Services and supplies of a home office that are allowable and patient related and are appropriately allocated to the nursing facility.

(3) Office and clerical staff.

(4) Legal and accounting fees.

(5) Advertising.

(6) Travel.

(7) Telephone.

(8) License dues and subscriptions.

(9) Office supplies.

(10) Working capital interest.

(11) State gross receipts taxes.

(12) Utilization review costs.

(13) Liability insurance.

(14) Management and other consultant fees.

(15) Qualified mental retardation professional (QMRP).

(b) As used in this rule, "allowable per patient day cost" means a ratio between allowable cost and patient days.

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

(d) As used in this rule, "average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable cost (including any applicable inflation adjustment) shall be computed on a statewide basis and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

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

(f) As used in this rule, "calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(g) As used in this rule, "capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property insurance.

(h) As used in this rule, "case mix index" (CMI) means a numerical value score that describes the relative resource use for each resident within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

(i) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(j) As used in this rule, "delinquent MDS resident assessment" means an assessment that is not electronically transmitted by the fifteenth day of the second month following the end of a calendar quarter, or an assessment that is greater than one hundred thirteen (113) days old, as measured by the R2b date field on the MDS.

(k) As used in this rule, "desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

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

(1) nursing and nursing aide services;
(2) nurse consulting services;
(3) pharmacy consultants;
(4) medical director services;
(5) nurse aide training;
(6) medical supplies;
(7) oxygen; and
(8) medical records costs.

(m) As used in this rule, "fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(n) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(o) As used in this rule, "forms prescribed by the office" means cost reporting forms provided by the office or substitute forms that have received prior written approval by the office.

(p) As used in this rule, "general line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(q) As used in this rule, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(r) As used in this rule, "incomplete MDS resident assessment" means an assessment that does not contain all data items that are required to classify a resident pursuant to the RUG-III resident classification system, for example, MDS RUG fields that include blanks, out-of-range, or inconsistent responses, or an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(s) As used in this rule, "indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

(1) Allowable dietary services and supplies.
(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.
(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.

(t) As used in this rule, "minimum data set (MDS)" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration.

(u) As used in this rule, "medical and nonmedical supplies and equipment" include those items generally required to assure adequate medical care and personal hygiene of patients.

(v) As used in this rule, "normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average case mix index (CMI) for all residents.

(w) As used in this rule, "office" means the office of Medicaid policy and planning.

(x) As used in this rule, "ordinary patient-related costs" means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

(y) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

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

(aa) As used in this rule, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

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

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

(dd) As used in this rule, "unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(ee) As used in this rule, "unsupported MDS resident assessment" means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system is not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15.

(ff) As used in this rule, "untimely MDS resident assessment" means a significant change MDS assessment, as defined by CMS' Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly; or a full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6(a) following the conclusion of all physical therapy, speech therapy, and occupational therapy. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462)*

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

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

Sec. 3. (a) Generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing change of provider transactions unless otherwise prescribed by this rule.

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

(c) In the event that a field audit indicates that the provider's records are inadequate to support data submitted to the office and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

(3) incorporate such adjustments in prospective rate calculations under subsection (d).

(d) Each provider shall submit confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.

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

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

(f) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report coincidental with the time period for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improve efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient-related lies with the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-3; filed Aug 12, 1998, 2:27 p.m.: 22 IR 71, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465)*

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

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

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office or its contractor. Any extension granted under this section may not exceed an additional ninety (90) days, for a total of one hundred eighty (180) days after the close of the provider's reporting year.

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

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

(d) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be

due twenty (20) days from the date of receipt of the disapproval from the office. Any extension granted under this section may not exceed an additional ninety (90) days, for a total of one hundred eighty (180) days after the close of the provider's reporting year.

(e) Failure to submit an annual financial report within the time limit required shall result in the following actions:

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

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. Extension of the electronic MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the new operation is not currently enrolled or submitting MDS assessments under the Medicare program and the provider can substantiate to the office circumstances that preclude timely electronic transmission.

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

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

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

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

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

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

(j) If the office or its contractor determines due to an MDS field audit that a nursing facility has untimely MDS resident assessments, then such assessment(s) shall be counted as an unsupported assessment for purposes of determining whether a corrective remedy shall be applied under subsection (k).

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

(1) The office or its contractor shall audit a sample of MDS resident assessments and will determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the sample that are unsupported is greater than the threshold percent as shown in column (B) of the table below, the office or its contractor shall expand the scope of the MDS audit to all residents. If the percent of assessments in the sample that are unsupported is equal to or less than the threshold percent as shown in column (B) of the table below, the office or its contractor shall conclude the MDS audit and no corrective remedy shall be applied.

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

(4) If the percent of assessments of all residents that are unsupported is greater than the threshold percent as shown in column (B) of the table below, a corrective remedy shall apply, which shall be calculated as follows. The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in column (C) of the table below. In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office or its contractor to the provider's allowable administrative costs. Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments of all residents that are unsupported is equal to or less than the threshold percent as shown

in column (B) of the table below, the office or its contractor shall conclude the audit and no corrective remedy shall apply. (6) The threshold percent and the administrative component corrective remedy percent in columns (B) and (C) of the table in this subdivision, respectively, shall be applied to audits begun by the office or its contractor on or after the effective date as stated in column (A) as follows:

Effective Date	Threshold Percent	Administrative Component Corrective Remedy Percent
(A)	(B)	(C)
October 1, 2002	40%	5%
January 1, 2004	30%	10%
April 1, 2005	20%	15%

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

(m) Beginning on the effective date of this rule, upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate, the rate shall be recalculated and any payment adjustment shall be made. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-4; filed Aug 12, 1998, 2:27 p.m.: 22 IR 72, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2240; errata filed Jun 21, 1999, 12:25 p.m.: 22 IR 3419; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465)*

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

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. 5. (a) Rate requests to establish an initial interim rate for a new operation shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date. Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, therapy, indirect care, administrative, and eighty percent (80%) of the capital component. Prior to the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted retroactively to reflect changes, occurring in the first and second calendar quarters of operation, in the provider's case mix index for Medicaid residents and adjusted prospectively after the second calendar quarter to reflect changes in the provider's case mix index for Medicaid residents. Initial interim rates shall be effective on the certification date or the date that a service is established, whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this rule shall apply.

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

(c) In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, a completed Checklist of Management Representations Concerning Change in Ownership shall be submitted to the office or its contractor. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office or its contractor. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-5; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2242; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2467)*

405 IAC 1-14.6-6 Active providers; rate review; requests due to change in law

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

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

(c) The rate effective date of the annual rate review shall be the first day of the second calendar quarter following the provider's reporting year end.

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

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

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

(g) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-6; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468)*

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

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

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

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

(b) Notwithstanding subsection (a), beginning on the effective date of this rule through September 30, 2003, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Prior to September 30, 2003, the office may reduce or eliminate the inflation reduction factor to increase aggregate expenditures up to levels appropriated by the Indiana general assembly. Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or

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

(d) The normalized average allowable cost of the median patient day for direct care costs and the average allowable cost of the median patient day for indirect care, administrative and capital-related costs shall not be less than the average allowable cost of the median patient day effective October 1, 1998.

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

(f) The case mix indices (CMIs) contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents, and the facility-average CMI for Medicaid residents.

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

Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

(g) The office or its contractor shall provide each nursing facility with the following:

(1) Two (2) preliminary CMI reports. These preliminary CMI reports serve as confirmation of the MDS assessments transmitted by the nursing facility, and provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments. The first preliminary report will be provided by the seventh day of the first month following the end of a calendar quarter. The second preliminary report will be provided by the seventh day of the second month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(h) The office may increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to such facilities at a rate of eight dollars and seventy-nine cents ($8.79) per Medicaid resident day. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468)*

405 IAC 1-14.6-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

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) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient utilization.

(b) Each facility and home office shall be allowed only one (1) patient care-related automobile to be included in the vehicle basis for purposes of computing the average historical cost of property of the median bed. As used in this subsection, "vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-8; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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

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

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

(1) The indirect care, administrative, and capital components, are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

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

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

(b) The profit add-on payment will be calculated as follows:

(1) For the direct care component, the profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) a provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

(2) For the indirect care component, the profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times one hundred percent (100%); minus

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

(3) For the administrative component, the profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times one hundred percent (100%); minus

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

(4) For the capital component, the profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times eighty percent (80%); minus

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

(5) For the therapy component, the profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate component limit defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs, times the facility-average case mix index for Medicaid residents times one hundred ten percent (110%).

(2) The average allowable cost of the median patient day for indirect care costs times one hundred percent (100%).

(3) The average allowable cost of the median patient day for administrative costs times one hundred percent (100%).

(4) The average allowable cost of the median patient day for capital-related costs times eighty percent (80%).

(5) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines shall be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a). *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470)*

405 IAC 1-14.6-10 Computation of rate; allowable costs; review of cost reasonableness

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. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report forms. Allowable patient care costs shall be clearly identified.

(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers throughout the state. The office or its contractors may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Personal or federal income taxes are not considered allowable costs. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-10; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-11 Allowable costs; services provided by parties related to the provider

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. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.
(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. A general partner is considered to control an entity.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to this subsection may be granted by the office if requested in writing by the provider before the annual rate review effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in subsection (e) has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, documentation to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties, such as invoices, standard charge master listings, and remittances, must be submitted.

(e) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization.
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.
(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-11; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.6-12 Allowable costs; fair rental value allowance

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. 12. Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is appropriately allocated to the facility.

(1) The fair rental value allowance is calculated by determining, on a per bed basis, the historical cost of allowable patient-

related property for facilities that are not acquired through an operating lease arrangement, including:

(A) land, building, improvements, vehicles, and equipment; and

(B) costs;

required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined above is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined above is extended times the number of beds for each facility that are used to provide nursing facility services, to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in section 6(a) of this rule. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-12; filed Aug 12, 1998, 2:27 p.m.: 22 IR 77, eff Oct 1, 1998; filed Sep 1, 2000, 2:10 p.m.: 24 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.6-13 Reporting of financing arrangements; working capital; interest; allocation of loans

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. (a) All patient-related property financing arrangements shall be fully and completely disclosed on the forms prescribed by the office.

(b) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities that are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(c) Interest on working capital loans shall only be recognized if the provider can demonstrate that such loans were reasonable and necessary in providing patient-related services. Working capital interest must be reduced by investment income from any related party. Working capital loans from a related party must be identified and reported separately on the annual financial report. Interest costs on related party working capital loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid at least annually for a minimum of thirty (30) days. Failure to document the existence of, or adhere to such repayment schedule, shall result in the related party working capital interest costs being disallowed.

(d) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-13; filed Aug 12, 1998, 2:27 p.m.: 22 IR 77, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-14 Property; basis; historical cost; mandatory record keeping; valuation

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. 14. (a) The basis used in computing the average historical cost of property of the median bed shall be the historical cost of all assets used to deliver patient-related services that meet the following conditions:

(1) The assets are in use.

(2) The assets are identifiable to patient care.

(3) The assets are available for physical inspection.

(4) The assets are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the average historical cost of property of the median bed.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances

of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the average historical cost of property of the median bed shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be capitalized and included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-14; filed Aug 12, 1998, 2:27 p.m.: 22 IR 78, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-15 Valuation; sale or lease among family members

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. 15. (a) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the average historical cost of property of the median bed except as described in this section for the sale of facilities between family members.

(b) If a sale of facilities between family members meets the following conditions, the cost basis of the facility shall be recognized for the purpose of computing the average historical cost of property of the median bed in accordance with this rule as a bona fide sale arising from an arm's-length transaction, subject to the limitations of subsection (c):

(1) There is no spousal relationship between parties.

(2) The following persons are considered family members:

(A) Natural parent, child, and sibling.

(B) Adopted child and adoptive parent.

(C) Stepparent, stepchild, stepsister, and stepbrother.

(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.

(E) Grandparent and grandchild.

(3) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.

(4) The seller is not associated with the facility in any way after the sale other than as a passive creditor.

(5) The buyer is actively engaged in the operation of the facility after the sale with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.

(6) This family sale exception has not been utilized during the previous eight (8) years on this facility.

(7) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.

(8) If any of the entities involved are corporations, they must be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.

(c) In order to establish a historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis for purposes of determining the average historical cost of property of the median bed shall be the lower of the historical cost basis of the buyer or the MAI appraisal of facilities and equipment.

(d) If a lease of facilities between family members under subsection (b)(2) qualifies as a capitalized lease under guidelines established by the American Institute of Certified Public Accountants, the transaction shall be treated as a sale of facilities between

family members for purposes of determining the average historical cost of property of the median bed. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-15; filed Aug 12, 1998, 2:27 p.m.: 22 IR 78, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-16 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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. 16. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient-related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-16; filed Aug 12, 1998, 2:27 p.m.: 22 IR 79, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-17 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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. 17. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided such employees are engaged in patient care-related functions and that compensation amounts are reasonable and allowable under this section and section 18 of this rule.

(b) The provider shall report on the forms prescribed by the office, all patient-related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported for all employees.

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

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be allowed if the compensation paid to owner/related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owner/related parties is not subject to the limitation found in section 18 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-17; filed Aug 12, 1998, 2:27 p.m.: 22 IR 79, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2246; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-18 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees

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. 18. (a) Compensation for owner, related party, management, general line personnel, and consultants who perform management functions, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is

allowed to cover costs for all administrative, policymaking, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks.

(b) The maximum amount of owner, related party, and management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (c), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) The owner, related party, and management compensation limitation per operation effective July 1, 1995, shall be as follows:

Owner and Management Compensation	
Beds	Allowance
10	$21,542
20	$28,741
30	$35,915
40	$43,081
50	$50,281
60	$54,590
70	$58,904
80	$63,211
90	$67,507
100	$71,818
110	$77,594
120	$83,330
130	$89,103
140	$94,822
150	$100,578
160	$106,311
170	$112,068
180	$117,807
190	$123,562
200	$129,298
200 and over	$129,298+ $262/bed over 200

This subsection applies to each provider of a Medicaid-certified operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-18; filed Aug 12, 1998, 2:27 p.m.: 22 IR 80, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-19 Medical or nonmedical supplies and equipment

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. 19. The approved per diem rate in nursing facilities includes the cost of both medical and nonmedical supply items, and the provider shall not bill the Medicaid program for such items in addition to the established rate. Under no circumstances shall medical or nonmedical supplies and equipment for nursing facility residents be billed through a pharmacy or other provider. Medical and nonmedical supply items for nursing facility residents that are reimbursed by other payor sources shall not be reimbursed by Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-19; filed Aug 12, 1998, 2:27 p.m.: 22 IR 80, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-20 Nursing facilities reimbursement for therapy services

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. 20. (a) Therapy services provided to Medicaid recipients by nursing facilities are included in the established rate. Under no circumstances shall therapies for nursing facility residents be billed to Medicaid through any provider. Therapy services for nursing facility residents that are reimbursed by other payor sources shall not be reimbursed by Medicaid.

(b) For purposes of determining allowable therapy costs, the office or its contractor shall adjust each provider's cost of therapy services reported on the Nursing Facility Financial Report, including any employee benefits prorated based on total salaries and wages, to account for non-Medicaid payers, including Medicare, of therapy services provided to nursing facility residents. Such adjustment shall be applied to each cost report in order to remove reported costs attributable to therapy services reimbursed by other payers. The adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-20; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470)*

405 IAC 1-14.6-21 Allocation of expenses

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. 21. (a) Except as provided in subsection (b), the detailed basis for allocation of expenses between nursing facility services and other services in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) The following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.

(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(3) Nothing in this rule is intended to alter the appropriate classification of costs on the annual financial report from the appropriate classification of costs under 405 IAC 1-14.1 *[405 IAC 1-14.1 was repealed filed May 30, 1997, 4:25 p.m.: 20 IR 2774.]*. No allocation of costs between annual financial report line items shall be permitted.

(4) Any changes in the allocation or classification of costs must be approved by the office prior to the changes being implemented. Proposed changes in allocation or classification methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-21; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15

Sec. 22. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

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

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider must request an administrative reconsideration from the MDS audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the MDS audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the MDS audit contractor shall evaluate the data. After review, the MDS audit contractor may amend the audit adjustment or affirm the original adjustment. The MDS audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the MDS audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-22; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; errata filed Jul 28, 1999, 3:10 p.m.: 22 IR 3937; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 15. Nursing Facilities; Electronic Transmission of Minimum Data Set

405 IAC 1-15-1 Scope

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. This section requires nursing facilities certified to provide nursing facility care to Medicaid recipients to electronically transmit minimum data set (MDS) information for all residents, including residents in a noncertified bed, to the office of Medicaid policy and planning for use in establishing and maintaining a case mix reimbursement system for Medicaid payments to nursing facilities and other Medicaid program management purposes. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-1; filed Nov 1, 1995, 8:30 a.m.: 19 IR 350; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471)*

405 IAC 1-15-2 Definitions

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

(b) "Case mix reimbursement" means a system of paying nursing facilities according to the mix of residents in each facility as measured by resident characteristics and service needs. Its function is to provide payment for resources needed to serve different types of residents.

(c) "Minimum data set" means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most

current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Health Care Financing Administration (HCFA).

(d) "Office" means the office of Medicaid policy and planning. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-2; filed Nov 1, 1995, 8:30 a.m.: 19 IR 350; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-15-3 General requirements

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) The office shall do the following:

(1) Adopt a schedule for nursing facility MDS data electronic transmission, based on the federal assessment schedule established by HCFA.

(2) Specify the method by which data shall be transmitted to the office, or its contractor, by nursing facilities.

(3) Provide nursing facilities with technical support in preparing MDS transmission to the office, or its contractor, including, but not limited to, the following:

(A) Providing training on the transmission of MDS data.

(B) Establishing standards for computer software and hardware for use in MDS data transmission.

(C) Any other support that the office deems necessary for successful transmission of MDS data.

(b) Allowable costs incurred by nursing facilities relating to transmission of MDS data to the office shall be reimbursed through the cost reporting mechanism established under 405 IAC 1-14.6. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-3; filed Nov 1, 1995, 8:30 a.m.: 19 IR 351; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-15-4 MDS supporting documentation requirements

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

Sec. 4. (a) The office shall publish supporting documentation guidelines for all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG-III resident classification system. The guidelines shall be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(b) Nursing facilities shall maintain supporting documentation in the resident's medical chart for all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG-III resident classification system. Such supporting documentation shall be maintained by the nursing facility for all residents in a manner that is accessible and conducive to audit. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-4; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-15-5 MDS audit requirements

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. 5. (a) The office or its contractor shall periodically audit the MDS supporting documentation maintained by nursing facilities for all residents, regardless of payer type. Such audits shall be conducted as frequently as deemed necessary by the office, and each nursing facility shall be audited no less frequently than every fifteen (15) months. Advance notification of up to seventy-two (72) hours shall be provided by the office or its contractor for all MDS audits, except for follow-up audits that are intended to ensure compliance with validation improvement plans. Advance notification for follow-up audits shall not be required.

(b) The MDS assessments subject to audit will include those assessments most recently transmitted to the office or its contractor in accordance with section 1 of this rule. The office may audit additional MDS assessments if it is deemed necessary. All supportive documentation to be considered for MDS audit must meet the criteria as specified in Section AA9 on the MDS Version 2.0 Basic Assessment Tracking Form.

(c) When conducting the MDS audits, the office or its contractor shall consider all MDS supporting documentation that is provided by the nursing facility and is available to the auditors prior to the exit conference. MDS supporting documentation that is provided by the nursing facility after the exit conference shall not be considered by the office.

(d) The nursing facility shall be required to produce, upon request by the office or its contractor, a computer generated copy of the MDS assessment that is transmitted in accordance with section 1 of this rule, which shall be the basis for the MDS audit.

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments have been transmitted, shall be referred to the Medicaid fraud control unit (MFCU) of the Indiana attorney general's office for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-5; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2249; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471)*

405 IAC 1-15-6 MDS assessment requirements

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. 6. Nursing facilities shall complete and transmit to the office or its contractor a new full or quarterly MDS assessment for all residents not in a continuing Medicare Part A stay after the conclusion of all physical, speech, and occupational therapies. This requirement only applies when the immediately preceding assessment for a resident classified him/her in the Rehabilitation category. Such new full or quarterly assessments shall be completed in order that the MDS assessment reference date (A3a) shall be no earlier than eight (8) days and no later than ten (10) days after the conclusion of all physical, speech, and occupational therapies. If the resident expires or is discharged from the facility, no such new full or quarterly assessment is required. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-6; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2249; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471)*

405 IAC 1-15-7 Nursing restorative programs

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. 7. For purposes of determining the amount of nursing restorative care that is credited to nursing facility residents that participate in group programs, the following MDS completion guideline shall apply. If an individual nursing facility resident is participating in a group nursing restorative program of four (4) or fewer participants, then the full amount of nursing restorative time shall be documented and recorded for all participants in such nursing restorative program. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-7; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2249; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 16. Reimbursement for Hospice Services

405 IAC 1-16-1 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) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified hospice providers that provide hospice care. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

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

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, and compensate providers for reasonable, allowable costs that must be incurred by efficiently and economically operated facilities. The system of payment outlined in this rule is a prospective system. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-1; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2377; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-16-2 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. 2. (a) Reimbursement for hospice care shall be made according to the methodology and amounts calculated by the Health Care Financing Administration (HCFA). Medicaid hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates will be adjusted for regional differences in wages using the geographical areas defined by HCFA and hospice wage index published by HCFA.

(b) Medicaid reimbursement for hospice services will be made at one (1) of four (4) all-inclusive per diem rates for each day in which a Medicaid recipient is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient hospice care.

(c) The hospice will be paid at the routine home care rate for each day the recipient is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(d) Continuous home care is to be provided only during a period of crisis. A period of crisis is defined as a period in which a patient requires continuous care that is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse, and a nurse must provide care for over half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day that begins and ends at midnight. This care need not be continuous and uninterrupted. The continuous home care rate is divided by twenty-four (24) hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty-four (24) hours a day.

(e) The hospice provider will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) consecutive days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(f) Subject to the limitations in section 3 of this rule, the hospice provider will be paid at the general inpatient hospice rate for each day the recipient is in an approved inpatient hospice facility and is receiving services related to the terminal illness. The recipient must require general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings. Documentation in the recipient's record must clearly explain the reason for admission and the recipient's condition during the stay in the facility at this level of care. No other fixed payment rate (i.e., routine home care) will be made for a day on which the patient receives general hospice inpatient care. Services provided in the inpatient setting must conform to the hospice patient's plan of care. The hospice provider is the professional manager of the patient's care, regardless of the physical setting of that care or the level of care. If the inpatient facility is not also the hospice provider, the hospice provider must have a contract with the inpatient facility delineating the roles of each provider in the plan of care.

(g) When routine home care or continuous home care is furnished to a recipient who resides in a nursing facility, the nursing facility is considered the recipient's home.

(h) Reimbursement for inpatient respite care is available only for a recipient who resides in a private home. Reimbursement for inpatient respite care is not available for a recipient who resides in a nursing facility. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2377; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-16-3 Limitation on payments for inpatient 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. 3. (a) Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid recipients. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next

year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid recipients during the same period by the designated hospice provider or its contracted agent or agents. For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice provider receives payment at a home care rate will not be counted as inpatient days.

(b) The limitations on payment for inpatient days are as follows:

(1) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).

(2) If the total number of days of inpatient care to Medicaid hospice recipients is less than or equal to the maximum number of inpatient days computed in subdivision (1), then no adjustment is made.

(3) If the total number of days of inpatient care to Medicaid hospice recipients is greater than the maximum number of inpatient days computed in subdivision (1), then the payment limitation will be determined by the following method:

(A) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made.

(B) Multiplying excess inpatient care days by the routine home care rate.

(C) Adding together the amounts calculated in clauses (A) and (B).

(D) Comparing the amount in clause (C) with total reimbursement made to the hospice provider for inpatient care during the cap period. The amount by which total reimbursement made to the hospice provider for inpatient care for Medicaid recipients exceeds the amount calculated in clause (C) is due from the hospice provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-16-3; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-16-4 Additional amount for nursing facility residents

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) An additional per diem amount will be paid directly to the hospice provider for room and board of hospice residents in a certified nursing facility receiving routine or continuous care services. In this context, "room and board" includes all assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

(b) The room and board rate will be ninety-five percent (95%) of the lowest per diem reimbursement rate Indiana Medicaid would have paid to the nursing facility for any resident for those dates of service on which the recipient was a resident of that facility.

(c) Medicaid payment to the nursing facility for nursing facility care for the hospice resident is discontinued when the resident makes an election to receive hospice care. Any payment to the nursing facility for furnishing room and board to hospice patients is made by the hospice provider under the terms of its agreement with the nursing facility.

(d) The additional amount for room and board is not available for recipients receiving inpatient respite care or general inpatient care. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-4; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-16-5 Reimbursement for physician 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. 5. (a) The basic payment rates for hospice care represent full reimbursement to the hospice provider for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice provider. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for hospice care.

(b) Reimbursement for a hospice employed physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Indiana Medicaid reimbursement methodology for physician services. These services will be billed by the hospice provider under the Medicaid hospice provider number. The only physician services to be billed separately from the hospice per diem are direct patient care services. Laboratory and x-ray services relating to the terminal condition are included in the hospice daily rate.

(c) Reimbursement for an independent physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Indiana Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice provider under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program when those services relate to the terminal condition. These costs are included in the daily rates paid and are expressly the responsibility of the hospice provider.

(d) Volunteer physician services are excluded from Medicaid reimbursement. However, a physician who provides volunteer services to a hospice may be reimbursed for nonvolunteer services provided to hospice patients. In determining which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid patients on the same basis as other hospice patients. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment for all physician services rendered to Medicaid patients. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-5; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 17. Rate-Setting Criteria for State-Owned Intermediate Care Facilities for the Mentally Retarded

405 IAC 1-17-1 Policy; scope

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 12-15-13-3; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified, state-owned intermediate care facilities for the mentally retarded (ICF/MR). All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

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

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, compensate providers for reasonable, allowable costs incurred by a prudent businessperson, and allow incentives to encourage efficient and economic operations. The system of payment outlined in this rule is a prospective system predicated on a reasonable, cost-related basis. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

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

(d) The office may implement Medicaid rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the office to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the office, providing the provider avails itself of the opportunity to make such an appeal. Interest shall be assessed in accordance with IC 12-15-13-3. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-1; filed Sep 1, 1998, 3:25 p.m.: 22 IR 83; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-2 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. 2. (a) As used in this rule, "all-inclusive rate" means a per diem rate which, at a minimum, reimburses for all nursing care, room and board, supplies, and ancillary therapy services within a single, comprehensive amount.

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

(c) As used in this rule, "budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

(d) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(e) As used in this rule, "office" means the office of Medicaid policy and planning.

(f) As used in this rule, "desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

(g) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(h) As used in this rule, "forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(i) As used in this rule, "general line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(j) As used in this rule, "generally accepted accounting principles" means those accounting principles as established by the American Institute of Certified Public Accountants.

(k) As used in this rule, "ICF/MR" means intermediate care facilities for the mentally retarded.

(l) As used in this rule, "like levels of care" means care provided in a state-operated ICF/MR.

(m) As used in this rule, "market area limitation (MAL)" means a rate ceiling for all Medicaid rates established by the office that is calculated on allowable costs using forecasted data submitted by providers when requesting rate review.

(n) As used in this rule, "ordinary patient related costs" means costs of services and supplies that are necessary in delivery of patient care by similar providers within the state.

(o) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

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

(q) As used in this rule, "unit of service" means all patient care at the appropriate skill level included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours). *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-2; filed Sep 1, 1998, 3:25 p.m.: 22 IR 83; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-3 Accounting records; retention schedule; audit trail; cash basis; segregation of accounts by nature of business and by location

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 basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider transactions unless otherwise prescribed by this rule.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The cash basis of accounting shall be used in all data submitted to the office. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit visit indicates that the provider's records are inadequate to support data submitted to the office, and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and certified to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this rule.

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

(e) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report and budget financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to generally accepted accounting principles, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, or quality of recipient care. The burden of demonstrating that costs are patient related lies with the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-3; filed Sep 1, 1998, 3:25 p.m.: 22 IR 84; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

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

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

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income.

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

(6) Schedule of Medicaid and private pay charges; private pay charges shall be lowest usual and ordinary charge on the last day of the reporting period.

(7) Certification by the provider that the data are true, accurate, related to patient care, and that expenses not related to patient care have been clearly identified.

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

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(d) Failure to submit an annual financial report in the time limit required shall result in the following actions:

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due, and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth

day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-4; filed Sep 1, 1998, 3:25 p.m.: 22 IR 85; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

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) Rate requests to establish initial interim rates for a new operation or a new type of certified service shall be filed by completing the budget financial report form and submitting it to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or new operation. The budget financial report shall reflect the forecasted data of operating for the first twelve (12) months and shall be subject to appropriate reasonableness tests. Initial interim rates shall be effective upon certification, or the date that a service is established, whichever is later.

(b) The methodology, set out in this rule, used to compute rates for active providers shall be followed to compute initial interim rates for new providers, except that historical data are not available.

(c) Since an initial interim rate is established based upon forecasted financial data only, the provider shall file a nine (9) month financial report within sixty (60) days following the end of the first nine (9) months of operation, together with forecasted data for twelve (12) months of operation. This twelve (12) month period of forecasted data shall start on the first day of the tenth month of certified operation of the facility. The nine (9) months of historical financial data and the twelve (12) months of forecasted data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of certified operation.

(d) The base rate may be in effect for longer or shorter than twelve (12) months of forecasted data. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the basis for the computation.

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

(f) In the event the provider fails to submit nine (9) months of historical financial data and the twelve (12) months of forecasted data as required in subsection (c), the following action shall be taken. When submission of the nine (9) months of historical financial data and the twelve (12) months of forecasted data is thirty (30) days past due, and an extension has not been granted, the initial rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after receipt of the report by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-5; filed Sep 1, 1998, 3:25 p.m.: 22 IR 85; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-6 Active providers; rate review; annual request; additional requests; requests due to change in law

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) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period. If the provider requests

that the rate be reviewed, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be prepared by the provider and submitted with the annual financial report.

(b) A provider shall not be granted an additional rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional rate review during its budget reporting year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical and forecasted data. This additional rate review shall be completed in the same manner as the annual rate review, using all other limitations in effect at the time the annual review took place.

(c) To request the additional review, the provider shall submit, on forms prescribed by the office, a minimum of six (6) months of historical data of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. In addition, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be submitted. Any new rate resulting from this additional review shall be effective on the first day of the month following the submission of data to the office.

(d) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office and will not be considered as an additional rate review. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-6; filed Sep 1, 1998, 3:25 p.m.: 22 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-7 Request for rate review; budget component; occupancy level assumptions; effect of inflation assumptions

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. Under this rate setting system, emphasis is placed on proper planning, budgeting, and cost control by the provider. To establish consistency in the submission and review of forecasted costs, the following apply:

(1) Each rate review request shall include a budget financial report. If a budget financial report is not submitted, the rate review will not result in an increase in Medicaid rates but may result in a rate decrease based on historical or annual financial reports submitted.

(2) All budget financial reports shall be submitted using forms prescribed by the office. All forecasted data and required attachments shall be completed to provide full financial disclosure and will include as a minimum the following:

(A) Patient census data.

(B) Statistical data.

(C) Ownership and related party information.

(D) Statement of all expenses and all income.

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

(F) Schedule of Medicaid and private pay charges; charges shall be the lowest usual and ordinary charge on the rate effective date of the rate review.

(G) Certification by the provider that forecasted data has been prepared in good faith, with appropriate care by qualified personnel, using appropriate accounting principles and assumptions, and that the process to develop the forecasted data uses the best information that is reasonably available and is consistent with the plans of the provider. The certification shall state that all expenses not related to patient care have been clearly identified or removed.

(H) Certification by the preparer, if the preparer is different from the provider, that the forecasted data were compiled from all information provided to the preparer and that the preparer has read the forecasted data with its summaries of significant assumptions and accounting policies and has considered them to be not obviously inappropriate.

(3) Forecasted data shall be based on a census figure of not less than eighty percent (80%). The provider shall adjust patient census data based on the highest of the following:

(A) Eighty percent (80%) of bed days available. Budget financial reports submitted to the office at less than eighty percent (80%) occupancy will not be considered as meeting the filing requirements of this section.

(B) Historical patient days for the most recent historical period unless the provider can justify the use of a lower figure for the patient days.

(C) Forecasted patient days for the twelve (12) month budget period.

(4) The provider and the office shall recognize and adjust forecasted data accordingly for the inflationary or deflationary effect

on historical data for the period between the midpoint of the historical or annual financial report time period and the midpoint of the budget financial report. Forecasted data may be adjusted based upon reasonably anticipated rates of inflation.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-7; filed Sep 1, 1998, 3:25 p.m.: 22 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-17-8 Limitations or qualifications to Medicaid reimbursement; advertising

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. Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations, fundraising, or to encourage patient utilization. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-8; filed Sep 1, 1998, 3:25 p.m.: 22 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-9 Criteria limiting rate adjustment granted by office

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. The Medicaid reimbursement system is based on recognition of the provider's allowable costs. The payment rate is subject to several limitations. Rates will be established at the lowest of the four (4) limitations listed as follows:

(1) A market area limitation (MAL) applies to all providers covered by this rule. The limitation shall be computed on a statewide basis using forecasted data submitted by providers for rate reviews. The market area limitation is an amount which shall be one hundred thirty percent (130%) of the average allowable cost, weighted by beds that are designated for like levels of care. The average allowable cost for like levels of care shall be maintained by the office, and a revision shall be made to this rate limitation four (4) times per year effective on March 1, June 1, September 1, and December 1.

(2) The calculated rate is the sum of the allowed per diem costs.

(3) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services.

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-9; filed Sep 1, 1998, 3:25 p.m.: 22 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-17-10 Computation of rate; allowable costs; review of cost reasonableness

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. (a) The rate for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total allowable costs and patient days, subject to all other limitations described in this rule.

(b) Costs and revenues shall be reported as required on the financial report forms. Patient care costs shall be clearly identified.

(c) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care in the same geographic area. The office may request satisfactory documentation from providers whose costs do not appear to be reasonable. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-10; filed Sep 1, 1998, 3:25 p.m.: 22 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-11 Allowable costs; capital reimbursement; depreciable life

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. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased. Such reimbursement shall include all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The straight line method will be used to calculate the allowance for depreciation. For depreciation purposes, the following will be used:

Property	Depreciable Life
Land improvements	20 years
Buildings and building components	40 years
Building improvements	20 years
Movable equipment	10 years
Vehicles	4 years
Software	3 years

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-11; filed Sep 1, 1998, 3:25 p.m.: 22 IR 88; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-17-12 Capital reimbursement; basis; historical cost; mandatory record keeping; valuation

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. (a) The basis used in computing the capital reimbursement shall be the historical cost of all assets used to deliver patient related services, provided the following:

(1) They are in use.

(2) They are identifiable to patient care.

(3) They are available for physical inspection.

(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the reimbursement.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing capital reimbursement shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donated asset are related parties, the net book value of the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-12; filed Sep 1, 1998, 3:25 p.m.: 22 IR 88; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-13 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-13; filed Sep 1, 1998, 3:25 p.m.: 22 IR 88; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-14 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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. (a) Reasonable compensation of individuals employed or to be employed by a provider is an allowable cost, provided such employees are engaged in, or will be engaged in, patient care-related functions and that forecasted compensation amounts are reasonable in light of historical data under this section and section 15 of this rule.

(b) The provider shall report on the financial report form in the manner prescribed, using the forms prescribed by the office, all patient related staff costs and hours incurred, and forecasted to be incurred, to perform the function for which the provider was certified. Both total compensation and total hours worked, and forecasted to be worked, shall be reported. If a service is performed through a contractual agreement, imputed hours for contracted services shall be reported.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. Said records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-14; filed Sep 1, 1998, 3:25 p.m.: 22 IR 89; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-15 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

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. (a) Compensation for management, consultant, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management and consultant functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractor, and consultant as well as any other individual or entity performing such tasks.

(b) The maximum amount of management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (d), as updated by the office on July 1 of each year by determining the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient related wages, salaries, or fees actually paid or withdrawn which were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) In addition to wages, salaries, and fees paid to owners under subsection (b), the office will allow up to twelve percent

(12%) of the appropriate schedule for fringe benefits, business expenses charged to an operation, and other assets actually withdrawn that are patient related. These expenses include fringe benefits that do not meet nondiscriminatory requirements of the Internal Revenue Code, entertainment, travel, or continuing education. Other assets actually withdrawn include only those items that were actually accrued and subsequently paid during the cost reporting period in which personal services were rendered and reported to the federal Internal Revenue Service as fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(d) The management compensation and expense limitation per operation effective July 1, 1995, shall be as follows:

	Owner and Management Compensation	Owner's Expenses
Beds	Allowance	(12% × bed allowance)
10	$21,542	$2,585
20	$28,741	$3,449
30	$35,915	$4,310
40	$43,081	$5,170
50	$50,281	$6,034
60	$54,590	$6,551
70	$58,904	$7,068
80	$63,211	$7,585
90	$67,507	$8,101
100	$71,818	$8,618
110	$77,594	$9,311
120	$83,330	$10,000
130	$89,103	$10,692
140	$94,822	$11,379
150	$100,578	$12,069
160	$106,311	$12,757
170	$112,068	$13,448
180	$117,807	$14,137
190	$123,562	$14,827
200	$129,298	$15,516
200 & over	$129,298+ $262/bed over 200	$15,516+ $31/bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-15; filed Sep 1, 1998, 3:25 p.m.: 22 IR 89; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-16 Allocation of costs

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. (a) The detailed basis for allocation of expense between different levels of care in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) However, the following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.

(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(3) Any change in the allocations must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-16; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-17-17 State-owned intermediate care facilities for the mentally retarded per diem rate

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. 17. The per diem rate for intermediate care facilities for the mentally retarded is an all-inclusive rate. The per diem rate includes all services provided to recipients by the facility. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-17; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-17-18 Administrative reconsideration; appeal

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. 18. (a) The Medicaid rate setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate setting contractor shall evaluate the data. After review, the Medicaid rate setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with a rate redetermination resulting from an audit adjustment, the provider must request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under 405 IAC 1-1.5.

(d) The office may take action to prospectively implement Medicaid rates without awaiting the outcome of the administrative process. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-18; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 18. Reimbursement of Medicare Cross-Over Claims

405 IAC 1-18-1 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 12-15-13; IC 12-15-14

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

(b) "Cross-over claim" means a Medicaid claim filed on behalf of a Medicare beneficiary who is also eligible for Medicaid. The term includes claims filed on behalf of beneficiaries who are eligible for Medicaid in any category, including, but not limited

to, qualified Medicare beneficiaries (QMBs) and beneficiaries who are eligible for full Medicaid coverage.

(c) "Medicaid allowable amount" means the reimbursement rate for a Medicaid claim as determined under state and federal law and policies. This reimbursement rate shall be the most recent rate on file with the office of Medicaid policy and planning or its contractor at the time a cross-over claim is processed.

(d) "Medicare coinsurance and deductible" means the Medicare cost-sharing costs described in 42 U.S.C. 1396d(p)(3)(B) through 42 U.S.C. 1396d(p)(3)(D).

(e) "Medicare payment amount" means the amount of payment made by Medicare to the provider for a given claim. It does not include coinsurance amounts or deductibles. *(Office of the Secretary of Family and Social Services; 405 IAC 1-18-1; filed Mar 18, 2002, 3:32 p.m.: 25 IR 2476)*

405 IAC 1-18-2 Reimbursement of nursing facility cross-over claims

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 12-15-14

Sec. 2. (a) Cross-over claims filed by nursing facilities are reimbursed as set out in this section.

(b) If the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero (0).

(c) If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

(1) the difference between the Medicaid allowable amount minus the Medicare payment amount; or

(2) the Medicare coinsurance and deductible, if any, for the claim.

(d) Cross-over claims filed by providers other than nursing facilities are reimbursed as described in section 3 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-18-2; filed Mar 18, 2002, 3:32 p.m.: 25 IR 2477)*

405 IAC 1-18-3 Reimbursement of cross-over claims filed by providers other than nursing facilities

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 12-15-13

Sec. 3. (a) Notwithstanding 405 IAC 1-1-3(f)(2), cross-over claims filed by providers other than nursing facilities are reimbursed as set out in this section.

(b) Medicaid reimbursement will be equal to the Medicare coinsurance and deductible, if any, for the claim.

(c) Cross-over claims filed by nursing facilities are reimbursed as described in section 2 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-18-3; filed Mar 18, 2002, 3:32 p.m.: 25 IR 2477)*

ARTICLE 1.1. APPEAL PROCEDURES FOR APPLICANTS AND RECIPIENTS OF MEDICAID

Rule 1. Administrative Law Judge Hearings

405 IAC 1.1-1-1 Purpose

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 1. (a) It is the purpose of this article to establish a uniform method of administrative adjudication for appeals concerning applicants and recipients of Medicaid, in order to determine whether or not any action complained of was done in accordance with federal and state statutes, regulations, rules, and policies. As used in this article, "policies" includes program manuals, administrative directives, transmittals, and other official written pronouncements of state or federal policy.

(b) This article shall be construed in such a manner as to provide all parties with an adequate opportunity to be heard in accordance with due process of law. As used in this article, "party" means:

(1) a person to whom the agency action is specifically directed;

(2) the office of Medicaid policy and planning; or

(3) the county office of family and children.

A contractor of the office of Medicaid policy and planning may act on behalf of the office for purposes of this article.

(c) In the event that any provision of this article is deemed to be in conflict with any other provision of federal or state statute, regulation, or rule that is specifically applicable to the Medicaid program, then such other statute, regulation, or rule shall supersede that part of this article in which the conflict is found. *(Office of the Secretary of Family and Social Services; 405 IAC 1.1-1-1; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3377; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1.1-1-2 Standing

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 2. (a) In the event that the rights, duties, obligations, privileges, or other legal relations of any person or entity are required or authorized by law to be determined by the office of Medicaid policy and planning or any county office of family and children, then such person or entity may request, as provided for in section 3 of this rule, an administrative hearing under this article. The person requesting the hearing shall be known as the appellant.

(b) Unless otherwise provided for by law, only those persons or entities, or their respective attorneys at law, whose rights, duties, obligations, privileges, or other legal relations are alleged to have been adversely affected by any action or determination by the office of Medicaid policy and planning or county office of family and children, may request an administrative hearing under this article. Any alleged harm to an appellant must be direct and immediate to the appealing parties and not indirect and general in character. *(Office of the Secretary of Family and Social Services; 405 IAC 1.1-1-2; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1.1-1-3 Filing an appeal; scheduling appeals

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 3. (a) Any party complaining of any office of Medicaid policy and planning or county office of family and children action in accordance with section 2 of this rule may file a request for an administrative hearing as provided in this section.

(b) Unless otherwise provided for by statute, regulation, or rule, appeal requests by recipients or applicants shall be filed in writing with the county office of family and children, the state division of family and children, or the hearings and appeals section of the family and social services administration, not later than thirty (30) days following the effective date of the action being appealed. Applicant and recipient appeal hearings shall be conducted at a reasonable time, place, and date.

(c) A continuance of a hearing will be granted only for good cause shown. An objection to a request for a continuance shall be considered before a continuance is granted or denied. Requests for a continuance shall be in writing and accompanied by adequate documentation of the reasons for the request. Good cause includes the same factors as cause for a continuance in the Supplemental Security Income program (20 CFR 416.1436):

(1) inability to attend the hearing because of a serious physical or mental condition;
(2) incapacitating injury;
(3) death in the family;
(4) severe weather conditions making it impossible to travel to the hearing;
(5) unavailability of a witness and the evidence cannot be obtained otherwise; or
(6) other reason similar to those listed in this section.

If the appellant is represented by counsel, the request for continuance must also include alternative dates for the scheduling of a new hearing. However, the hearings and appeals section may schedule a new hearing without respect to the requested date if such date cannot be accommodated or confirmed with the requesting attorney within a reasonable time of the request.

(d) The hearings and appeals section of the family and social services administration, upon application of any party, or in its own discretion, may consolidate appeals to promote administrative efficiency. Hearings and appeals may consolidate hearings only in cases in which the sole issue involved is one of federal or state law or policy.

(e) Any party filing an appeal under this article is not excused from exhausting all interim procedures that may be required by statute or rule for administrative review prior to the filing of an appeal. Any issues not preserved in a timely manner within the interim review procedures are waived and shall not be an issue during the evidentiary hearing.

(f) The hearings and appeals section of the family and social services administration will schedule evidentiary hearings and

issue notices to the parties regarding the date, time, and location of the scheduled hearing. *(Office of the Secretary of Family and Social Services; 405 IAC 1.1-1-3; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1.1-1-4 Conduct and authority of administrative law judge

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 4. (a) An administrative law judge's (ALJ) conduct shall be in a manner that promotes public confidence in the integrity and impartiality of the administrative hearing process. The ALJ who conducts a hearing is prohibited from:

(1) consulting any party or party's agent on any fact in issue unless upon notice and opportunity for all parties to participate;

(2) performing any of the investigative or prosecutorial functions of the agency in the administrative action heard or to be heard by him or her or in a factually related administrative or judicial action;

(3) being influenced by partisan interests, public clamor, or fear of criticism;

(4) conveying or permitting others to convey the impression that they are in a special position to influence the ALJ;

(5) commenting publicly, except as to hearing schedules or procedures, about pending or impending proceedings; or

(6) engaging in financial or business dealings that tend to:

(A) reflect adversely on his or her impartiality;

(B) interfere with the proper performance of his or her duties;

(C) exploit the ALJ's position; or

(D) involve the ALJ in frequent financial business dealings with attorneys or other persons who are likely to come before the ALJ.

(b) An ALJ shall disqualify himself or herself in a proceeding in which his or her impartiality might reasonably be questioned, or in which the ALJ's personal bias, prejudice, or knowledge of a disputed evidentiary fact might influence the decision. Nothing in this subsection prohibits a person who is an employee of an agency from serving as an ALJ.

(c) The ALJ shall be authorized to:

(1) administer oaths and affirmations;

(2) issue subpoenas;

(3) rule upon offers of proof;

(4) receive relevant evidence;

(5) facilitate discovery in accordance with the Indiana rules of trial procedure;

(6) regulate the course of the hearing and conduct of the parties;

(7) hold informal conferences for the settlement or simplification of the issues under appeal;

(8) dispose of procedural motions and similar matters; and

(9) exercise such other powers as may be given by the law relating to the Medicaid program.

(Office of the Secretary of Family and Social Services; 405 IAC 1.1-1-4; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1.1-1-5 Conduct of hearing

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 5. (a) The administrative law judge (ALJ) shall conduct the hearing in an informal manner and without recourse to the technical common law rules of evidence.

(b) The ALJ shall exclude from consideration irrelevant, immaterial, or unduly repetitious evidence.

(c) Every party shall have the right to submit evidence. In the event that an objection to evidence is sustained, the party proffering the evidence may make an offer of proof. Each party shall have the right to cross-examine the witnesses and offer rebutting evidence. *(Office of the Secretary of Family and Social Services; 405 IAC 1.1-1-5; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1.1-1-6 Hearing decision

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 6. (a) Following the completion of the hearing, or after the submission of briefs by the parties (if briefing is permitted by the ALJ), the administrative law judge shall issue his or her decision in the matter concurrently to the parties. The decision shall be final unless a party requests agency review of the decision in accordance with 405 IAC 1.1-2.

(b) The ALJ's decision shall:

(1) include findings of fact;

(2) specify the reasons for the decision; and

(3) identify the evidence and statutes, regulations, rules, and policies supporting the decision.

(c) The findings of fact need not include a recitation of every piece of evidence admitted in the evidentiary hearing. Rather, the findings should contain the basic facts that have formed the basis for the ALJ's ultimate decision. The decision must demonstrate a rational connection between the basic facts found by the ALJ and the ALJ's ultimate decision. The ALJ's decision must also cite the relevant laws upon which the ultimate decision is based, and relate the facts to the law. *(Office of the Secretary of Family and Social Services; 405 IAC 1.1-1-6; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 2. Agency Review

405 IAC 1.1-2-1 Conduct of agency review

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 4-21.5-3-33; IC 12-15-28

Sec. 1. (a) Any party who is not satisfied with the decision of the administrative law judge may request agency review of the decision within ten (10) days of receipt thereof in accordance with instructions issued with the decision.

(b) After receiving a request for agency review of a hearing decision, the hearings and appeals section of the family and social services administration shall notify all parties when the decision will be reviewed. The agency review shall be completed by the secretary of the family and social services administration or the secretary's designee. All such reviews shall be conducted upon the record as defined in IC 4-21.5-3-33, except that a transcript of the oral testimony shall not be necessary for review unless a party requests that one be transcribed at the party's expense.

(c) No new evidence will be considered during the agency review; however, any party wishing to submit a memorandum of law, citing evidence in the record, may do so pursuant to instructions issued by the hearings and appeals section of the family and social services administration. *(Office of the Secretary of Family and Social Services; 405 IAC 1.1-2-1; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1.1-2-2 Decision on agency review

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 2. (a) The secretary of family and social services administration or the secretary's designee shall review the administrative law judge's (ALJ) decision to determine if the decision is supported by the evidence in the record and is in accordance with the statutes, regulations, rules, and policies applicable to the issue under appeal.

(b) Following the review of the secretary or designee, the secretary or designee shall issue a written decision:

(1) affirming the decision of the ALJ;

(2) amending or modifying the decision of the ALJ;

(3) reversing the decision of the ALJ;

(4) remanding the matter to the ALJ for further specified action; or

(5) make such other order or determination as is proper on the record.

(c) The parties will be issued a written notice of the action taken as a result of the agency review. If the decision of the ALJ is reversed, amended, or modified, the secretary or designee shall state the reasons for the action in the written decision.

(d) The hearings and appeals section of the family and social services administration shall distribute the written notice on

agency review to:

(1) all parties of record;

(2) the assistant secretary for office of Medicaid policy and planning;

(3) the ALJ who rendered the decision following the evidentiary hearing; and

(4) any other person designated by the secretary or the designee.

(Office of the Secretary of Family and Social Services; 405 IAC 1.1-2-2; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Rule 3. Judicial Review

405 IAC 1.1-3-1 Judicial review

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 4-21.5-3-33; IC 4-21.5-5; IC 12-15-28

Sec. 1. (a) If the Medicaid applicant or recipient is not satisfied with the final action after agency review, he or she may file a petition for judicial review in accordance with IC 4-21.5-5.

(b) The Medicaid applicant or recipient is required to seek agency review prior to filing a petition for judicial review.

(c) The record of the administrative proceedings shall be that as defined in IC 4-21.5-3-33. *(Office of the Secretary of Family and Social Services; 405 IAC 1.1-3-1; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

ARTICLE 2. MEDICAID RECIPIENTS; ELIGIBILITY

Rule 1. General Requirements; Medicaid Recipient Eligibility

405 IAC 2-1-1 Definitions

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 1. (a) As used in this article, "applicant" means the person for whom medical assistance is requested.

(b) As used in this article, "dependent child" means a nonrecipient child under eighteen (18) years of age or between eighteen (18) and twenty-one (21) years of age and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him or her for gainful employment. A dependent child must be the biological or adoptive child of the applicant or recipient or the biological or adoptive child of the applicant's or recipient's parent.

(c) As used in this article, "essential person" means a person who is not the applicant's or recipient's spouse or parent, who lives in the place of residence of the applicant or recipient, and who is considered by the applicant or recipient to be essential to his or her well-being because he or she provides services to the applicant or recipient which would have to be paid for otherwise.

(d) As used in this article, "nonrecipient" means a person who is not receiving medical assistance.

(e) As used in this article, "parent(s)" means the biological or adoptive parent(s) living with an unmarried applicant or recipient who is either:

(1) under eighteen (18) years of age; or

(2) between eighteen (18) and twenty-one (21) years of age and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him or her for gainful employment.

(f) As used in this article, "recipient" means a person who is receiving medical assistance.

(g) As used in this article, "spouse" means the legal husband or wife of an applicant or recipient who is either living with the applicant or recipient or physically separated from him or her only for medical reasons. *(Office of the Secretary of Family and Social Services; 405 IAC 2-1-1; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1012, eff Apr 1, 1984; filed Jun 19, 1984, 10:25 a.m.: 7 IR 1820, eff Jul 1, 1984 [IC 4-22-2-5 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #84-29 was filed Jun 19, 1984.]; filed Apr 10, 1985, 2:20 p.m.: 8 IR 989; filed Apr 4, 1986, 11:07 a.m.: 9 IR 1854; filed Aug 15, 1986, 3:00 p.m.: 10 IR 6; filed May 11, 1987, 9:30 a.m.: 10 IR 1864; filed Apr 26, 1988, 12:55 p.m.: 11 IR 3028; filed*

Oct 6, 1989, 4:50 p.m.: 13 IR 282; filed May 2, 1990, 4:55 p.m.: 13 IR 1704; filed Aug 9, 1991, 11:00 a.m.: 14 IR 2224; filed May 14, 1992, 5:00 p.m.: 15 IR 2189; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1780; filed Nov 26, 1996, 4:30 p.m.: 20 IR 955; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-1-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-1-2 Interview of applicants and recipients

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 2. (a) In addition to the requirements of 470 IAC 2.1-1-2, each applicant for and recipient of medical assistance or the individual authorized to act in the individual's behalf must be interviewed by the county office at the time of the initial investigation and at each annual reinvestigation of eligibility.

(b) An application for medical assistance shall be filed on the form prescribed by the division of family and children.

(c) The applicant or recipient may use an authorized representative to apply for medical assistance, to represent the applicant or recipient in all interviews, and to notify the county office of any changes. The authorization must be in writing except as provided in subsections (e) and (f).

(d) Notwithstanding the availability of an authorized representative, the county office may require personal contact with the applicant or recipient in order to obtain information necessary for the determination of eligibility.

(e) The parents of an applicant or recipient under twenty-one (21) years of age may apply for medical assistance on behalf of the applicant or recipient without the written authorization specified in subsection (c).

(f) The written authorization specified in subsection (c) shall not be required if medical documentation shows that the applicant or recipient is medically unable to provide such authorization.

(g) An applicant or recipient who does not meet the requirements of this section shall be ineligible for medical assistance. *(Office of the Secretary of Family and Social Services; 405 IAC 2-1-2; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1013, eff Apr 1, 1984; filed Jun 19, 1984, 10:25 a.m.: 7 IR 1821, eff Jul 1, 1984 [IC 4-22-2-5 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #84-29 was filed with the secretary of state June 19, 1984.]; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1781; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-2) to the Office of the Secretary of Family and Social Services (405 IAC 2-1-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-1-3 Date of application for assistance

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 3. For the purpose of determining when notice of the decision to approve or deny assistance must be mailed to an applicant for medical assistance under 42 CFR 435.911, the date of application is the date on which the application for assistance, Part I, is received by the county office. *(Office of the Secretary of Family and Social Services; 405 IAC 2-1-3; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1013, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1781; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-3) to the Office of the Secretary of Family and Social Services (405 IAC 2-1-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

Rule 2. Eligibility Requirements Other than Need

405 IAC 2-2-1 Age requirement; medical assistance for the aged

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. In order to be eligible for assistance under the medical assistance for the aged program as an aged person, the applicant must be at least sixty-five (65) years of age. *(Office of the Secretary of Family and Social Services; 405 IAC 2-2-1; filed Mar 1, 1984, 2:31 pm: 7 IR 1014, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-1) by*

P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-2-2 Visual eligibility; medical assistance for the blind

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) An individual is visually eligible for the medical assistance for the blind program if he has central visual acuity of 20/200 or less in the better eye with correction or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance of no greater than 20 degrees.

(b) Each applicant for medical assistance for the blind is required to undergo an eye examination by a qualified examiner as defined in IC 12-1-1-1(o) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* unless:

(1) verification is obtained that the individual is currently receiving supplemental security income (SSI) benefits based on blindness; or

(2) reexaminations have been waived by the supervising ophthalmologist of the state department.

(c) The determination of visual eligibility of an applicant or recipient shall be made by the supervising ophthalmologist of the state department upon receipt of a written report on the form prescribed by the state department or in any other format that contains the same information as requested on this form. This report must be completed by the eye examiner and must be based on an examination given not more than six (6) months prior to the date of the eye examiner's report.

(d) The supervising ophthalmologist of the state department may require additional examinations in order to determine visual eligibility. *(Office of the Secretary of Family and Social Services; 405 IAC 2-2-2; filed Mar 1, 1984, 2:31 pm: 7 IR 1014, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-2) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-2-3 Disability determination

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 12-14-15-1; IC 12-15

Sec. 3. (a) The determination of whether an applicant or recipient is disabled according to the definition of disability prescribed in IC 12-14-15-1(2) is made by the Medicaid medical review team (MMRT) based upon the following principles:

(1) The determination of whether a condition appears reasonably certain to result in death or that has lasted or appears reasonably certain to last for a continuous period of at least four (4) years without significant improvement is made on the basis of the expected duration of the condition. A condition which is temporary (less than four (4) years) or transient does not fulfill this requirement. The expected duration of the condition does not preclude the possibility of future medical advances, changed diagnosis or prognosis, unforeseen recovery, or successful treatment subsequent to the initial prognosis.

(2) The determination of whether a condition substantially impairs the applicant's ability to perform labor or services or to engage in a useful occupation will be made based upon a consideration of the following:

(A) The applicant's functional limitations, as follows:

(i) Consideration is given to the applicant's significant physical functions and capacity which affect vocational capacity such as standing, walking, lifting, range of motion, strength, agility, and stamina.

(ii) Consideration is given to the individual's intellectual and sensory functions which affect vocational capacity such as sight, speech, hearing, reasoning, and following directions.

(iii) Consideration is given to the applicant's capacity for sustained activity on a regular basis.

(B) The applicant's age, as follows:

(i) An individual who is not engaged in a useful occupation solely because of age cannot be found disabled if the individual's impairment, education, and work experience would enable the individual to function in a useful capacity.

(ii) If the applicant is over fifty-five (55) years of age, the applicant's age may be considered a significant factor in the applicant's ability to engage in or adapt to a useful occupation.

(iii) If the applicant is under eighteen (18) years of age, the applicant's condition is evaluated in terms of how it affects the applicant's activities and restricts the applicant's physical, mental, emotional, and social growth,

learning, and development.

(iv) A condition which is likely to substantially impair a child's ability to become an independent and self-supporting adult is a basis for a finding of disability.

(C) The applicant's education and training, as follows:

(i) Consideration is given to the applicant's formal schooling and other training that contributes to the applicant's ability to meet vocational requirements.

(ii) Past work experience, daily activities, and hobbies are considered in determining and evaluating skills not acquired in a formal setting.

(iii) In determining whether these factors are vocationally significant, consideration is given to the time elapsed since the completion of education, training, or the exercise of acquired skills.

(iv) Lack of education and training is not of itself a basis for a finding of disability.

(D) The applicant's work experience, as follows:

(i) The applicant's inability to engage in the applicant's former occupation is not, in itself, a basis for a finding of disability.

(ii) Work performed fifteen (15) or more years prior to an application is not considered vocationally relevant. Similarly, an individual who has no work experience or only sporadic work experience in the previous fifteen (15) years is considered to have no work experience relevant to the determination of disability.

(iii) The absence of work experience is not in itself a basis for a finding of disability.

(iv) If an applicant is physically or mentally unable to engage in any previous occupation but the applicant's remaining functional capacity and vocational capabilities are sufficient to meet the demands and adjustments required by a different occupation, the applicant is not considered disabled.

(b) Except as provided below, a redetermination of disability is required annually of each recipient at the time the county office does its complete redetermination of all factors of eligibility. Redeterminations of disability may be required more frequently or may be waived at the discretion of the MMRT based upon the condition of the recipient. *(Office of the Secretary of Family and Social Services; 405 IAC 2-2-3; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1015, eff Apr 1, 1984; errata, 7 IR 1254; filed Dec 21, 2000, 2:06 p.m.: 24 IR 1342; errata filed Apr 30, 2001, 3:27 p.m.: 24 IR 2709; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-3) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-2-4 Payment for examinations and tests

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

Sec. 4. The office of Medicaid policy and planning (office) shall pay for the costs of necessary medical examinations and diagnostic tests required to determine whether the applicable visual or disability requirement is met to qualify for Medicaid to the blind or disabled, subject to the following limitations:

(1) Payment will be made only to the medical practitioner upon submission of a completed claim form prescribed by the office.

(2) Payment for the cost of submitting a report of a previously completed medical examination or other record shall not exceed ten dollars ($10).

(3) Payment for an eye examination and completion of a report thereon shall not exceed twenty-nine dollars ($29).

(4) Payment for a physical examination or evaluation and completion of a report thereon shall not exceed sixty-five dollars ($65). Examination fees include expenses for basic blood testing and urinalysis. Fees relating to these tests will not be reimbursed separately.

(5) Payment for a psychiatric evaluation or testing and completion of a report thereon shall not exceed eighty dollars ($80) per hour.

(6) Diagnostic procedures, such as laboratory tests, x-rays, and special testing, may be reimbursed only if authorized in advance of the procedure by the Medicaid medical review team (MMRT) physician. Authorization will only be granted if additional testing is necessary in order to:

(A) confirm the diagnosis or to measure the severity of the impairment; or

(B) assist in completing the examination.

Payment will not be made for any treatment given to the applicant.

(7) All prior-authorized additional testing, as referenced in subdivision (6), will be reimbursed according to the Medicaid fee-for-service schedule applicable on the date of service.

(Office of the Secretary of Family and Social Services; 405 IAC 2-2-4; filed Nov 1, 1995, 8:30 a.m.: 19 IR 351; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Rule 3. Eligibility Requirements Based on Need; Aged, Blind, and Disabled Program

NOTE: 405 IAC 2-3 was transferred from 470 IAC 9.1-3. Wherever in any promulgated text there appears a reference to 470 IAC 9.1-3, substitute 405 IAC 2-3.

405 IAC 2-3-1 Transfer of property to meet eligibility requirements (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Mar 13, 2002, 10:09 a.m.: 25 IR 2475)*

405 IAC 2-3-1.1 Transfer of property; penalty

Authority: IC 12-8-1-9; IC 12-8-6-5; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5; IC 12-15-39.6

Sec. 1.1. (a) The following definitions apply throughout this section:

(1) "Assets" includes all income and resources of the applicant or recipient, and of the applicant's or recipient's spouse, including any income or resources which the applicant or recipient or the applicant's or recipient's spouse is entitled to receive but does not receive because of action:

(A) by the applicant or recipient or the applicant's or recipient's spouse;

(B) by a person, including, but not limited to, a court or administrative body, with legal authority to act in place of or on behalf of the applicant or recipient or the applicant's or recipient's spouse; or

(C) by a person, including, but not limited to, a court or administrative body, acting at the direction or upon the request of the applicant or recipient or the applicant's or recipient's spouse.

The term includes assets that an individual is entitled to receive but does not receive because of failure to take action, subject to subsection (i).

(2) "Individual" means an applicant or recipient of Medicaid.

(3) "Institutionalized individual" means an applicant or recipient who is:

(A) an inpatient in a nursing facility;

(B) an inpatient in a medical institution for whom payment is made based on a level of care provided in a nursing facility; or

(C) who is receiving home and community-based waiver services.

(4) "Net income" means the income produced by real property after deducting allowable expenses of ownership. Allowable and nonallowable expenses are as follows:

(A) The following are allowable expenses of ownership if the owner is responsible for the expenses:

(i) Property taxes.
(ii) Interest payments.
(iii) Repairs and maintenance.
(iv) Advertising expenses.
(v) Lawn care.
(vi) Property insurance.
(vii) Trash removal expenses.
(viii) Snow removal expenses.
(ix) Utilities.
(x) Any other expenses of ownership allowed by the Supplemental Security Income program.

(B) The following are not allowable expenses of ownership:

(i) Depreciation.
(ii) Payments on mortgage principal.

(iii) Personal expenses of the owner.
(iv) Mortgage insurance.
(v) Capital expenditures.

(5) "Noninstitutionalized individual" means an applicant or recipient receiving any of the services described in subsection (e).

(6) "Qualified long term care insurance policy" has the meaning in 760 IAC 2-20-30.

(7) "Uncompensated value" means the difference between the fair market value of the asset and the value of the consideration received by the applicant or recipient in return for transferring the asset.

(b) A transfer of assets includes any cash, liquid asset, or property that is transferred, sold, given away, or otherwise disposed of as follows:

(1) Transfer includes any total or partial divestiture of control or access, including, but not limited to, any of the following:
(A) Converting an asset from individual to joint ownership.
(B) Relinquishing or limiting the applicant's or recipient's right to liquidate or sell the asset.
(C) Disposing of a portion or a partial interest in the asset while retaining an interest.
(D) Transferring the right to receive income or a stream of income, including, but not limited to, income produced by real property.
(E) Renting or leasing real property.
(F) Waiving the right to receive a distribution from a decedent's estate, or failing to take action to receive a distribution that the individual is entitled to receive by law, subject to subsection (i).

(2) If an applicant or recipient relinquishes ownership or control over a portion of an asset, but retains ownership, control, or an interest in the remaining portion, the portion relinquished is considered transferred.

(3) A transfer of the applicant's or recipient's assets completed by the applicant's or recipient's power of attorney or legal guardian is considered a transfer by the applicant or recipient.

(4) For purposes of this section, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered transferred by the applicant or recipient when any action is taken, either by the applicant or recipient or by any other person, that reduces or eliminates the applicant's or recipient's ownership or control of the asset.

(5) This section applies without regard to the exclusion of the home described in 42 U.S.C. 1382b(a)(1).

(c) If an applicant or recipient of Medicaid, or the spouse of an applicant or recipient, disposes of assets for less than fair market value on or after the look-back date specified in this subsection, the applicant or recipient is ineligible for medical assistance for services described in subsections (d) through (e), for a period beginning on the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other periods of ineligibility under this section. The ineligibility period is equal to the number of months specified in subsection (f). The look-back date is determined as follows:

(1) In the case of transfers that do not involve a trust, the look-back date is determined as follows:
(A) For an institutionalized individual, the look-back date is thirty-six (36) months before the first date as of which the individual both:
(i) is an institutionalized individual; and
(ii) has applied for medical assistance.
(B) For a noninstitutionalized individual, the look-back date is thirty-six (36) months before the later of:
(i) the date on which the individual applies for medical assistance; or
(ii) the date on which the individual disposes of assets for less than fair market value.

(2) In the case of transfers which involve payments from a trust or portions of a trust that are treated as assets disposed of by an applicant or recipient under section 22(b)(3) or 22(c)(2) of this rule, the look-back date is determined as follows:
(A) For an institutionalized individual, the look-back date is sixty (60) months before the first date as of which the individual both:
(i) is an institutionalized individual; and
(ii) has applied for medical assistance.
(B) For a noninstitutionalized individual, the look-back date is sixty (60) months before the later of:
(i) the date on which the individual applies for medical assistance; or
(ii) the date on which the individual disposes of assets for less than fair market value.

(d) During the penalty period, an institutionalized individual is ineligible for medical assistance for the following services:

(1) Nursing facility services.

(2) A level of care in any institution equivalent to that of nursing facility services.

(3) Home or community-based waiver services.

(e) During the penalty period, a noninstitutionalized individual is ineligible for the following services:

(1) Home health care services.

(2) Home and community care services for functionally disabled elderly individuals.

(3) Personal care services as defined in 42 U.S.C. 1396a(a)(24).

(4) Any other long term care services, including, but not limited to, the services listed in subsection (d).

(f) The number of months of ineligibility shall be equal to the total, cumulative uncompensated value of all assets transferred by the individual, or the individual's spouse, on or after the look-back date specified in subsection (c), divided by the average monthly cost to a private patient of nursing facility services in the geographic area which includes the county where the individual resides at the time of application. As used in this subsection, "geographic area" means the region identified in Section 2640.10.35.20 of the Family and Social Services Administration Program Policy Manual for Cash Assistance, Food Stamps, and Health Coverage.

(g) This subsection applies to the transfer of a stream of income, including, but not limited to, the transfer of the income generated by income-producing real property. The transfer of income-producing real property is a transfer of a stream of income if the transferor does not retain the right to receive the income generated by the property. The uncompensated value of income transferred is determined by calculating the greater of:

(1) the fair market value; or

(2) the actual amount;

of total net income that the property or other source of income is expected to produce during the lifetime of the transferor, based on life expectancy tables published by the office, and subtracting the income, if any, that the transferor will receive from the property or other source of income after the transfer.

(h) When an individual accepts a rental payment that is less than the fair market rental value for income-producing property, the uncompensated value of the transfer is determined by:

(1) calculating the difference between the fair market rental value and the amount of rent accepted; and

(2) multiplying the difference by the person's life expectancy based on life expectancy tables published by the office.

(i) This subsection applies to a transfer of assets that results from failure to take action to receive assets to which one is entitled to receive by law. No penalty will be imposed if any of the following circumstances applies:

(1) The applicant or recipient, or the individual with legal authority to act on behalf of the applicant or recipient, is unaware of his or her right to receive assets, or becomes aware of the right to receive assets after the deadline for taking action has passed. If the office notifies the applicant or recipient of his or her right to receive assets prior to the deadline for taking action, the individual will be presumed to be aware of his or her right to receive assets unless subdivision (2) applies.

(2) A physician states that the applicant or recipient is not capable of taking action to receive the assets, and there is no guardian or other individual with the authority to act on the applicant's or recipient's behalf.

(3) The expenses of collecting the assets would exceed the value of the assets.

(4) In the case of a surviving spouse who fails to take a statutory share of a deceased spouse's estate, no penalty will be imposed if the deceased spouse has made other equivalent arrangements to provide for a spouse's needs. "Other equivalent arrangements" includes, but is not limited to, a trust established for the benefit of the surviving spouse.

(j) An applicant or recipient shall not be ineligible for medical assistance under this section if any of the following apply:

(1) The assets transferred were a home, and title to the home was transferred to any of the following persons:

(A) The spouse of the applicant or recipient.

(B) A child of the applicant or recipient who:

(i) is under twenty-one (21) years of age; or

(ii) is blind or disabled as defined in 42 U.S.C. 1382c.

(C) A sibling of the applicant or recipient who has an equity interest in the home and who was residing in the applicant's or recipient's home for a period of at least one (1) year immediately before the date the applicant or recipient becomes an institutionalized individual.

(D) A son or daughter of the applicant or recipient, other than a child described in clause (B), who was residing in the applicant's or recipient's home for a period of at least two (2) years immediately before the date the applicant or recipient becomes an institutionalized individual, and who the office determines has provided care to the applicant or

recipient which permitted the applicant or recipient to reside at home rather than in an institution or facility.

(2) The assets were transferred to the applicant's or recipient's spouse or to another for the sole benefit of the applicant's or recipient's spouse.

(3) The assets were transferred from the applicant's or recipient's spouse to another for the sole benefit of the applicant's or recipient's spouse.

(4) The assets were transferred to:

(A) the applicant's or recipient's child who is disabled or blind as defined in 42 U.S.C. 1382c; or

(B) to a trust, including a trust described in section 22(i) of this rule, established solely for the benefit of the applicant's or recipient's child who is disabled or blind as defined in 42 U.S.C. 1382c.

(5) The assets were transferred to a trust, including a trust described in section 22(i) of this rule, established solely for the benefit of an individual under sixty-five (65) years of age who is disabled as defined in 42 U.S.C. 1382c.

(6) The assets transferred are disregarded for eligibility purposes through the use of a qualified long term care insurance policy pursuant to IC 12-15-39.6. If an asset is disregarded through the use of a qualified long term care insurance policy, that asset and any income generated by that asset may be transferred without penalty.

(7) A satisfactory showing is made to the office, in accordance with standards specified under 42 U.S.C. 1396p(c)(2)(C) by the Secretary of Health and Human Services, that:

(A) the applicant or recipient intended to dispose of the assets at fair market value or for other valuable consideration;

(B) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or

(C) all assets transferred for less than fair market value have been returned to the applicant or recipient.

(8) The office may waive the application of this section in cases of undue hardship, but only to the extent required by standards specified under 42 U.S.C. 1396p(c)(2)(D) by the Secretary of Health and Human Services.

(k) In the case of a transfer by the spouse of an applicant or recipient which results in a period of ineligibility for medical assistance, the office shall apportion the period of ineligibility, or any portion of that period, between the applicant or recipient and the applicant's or recipient's spouse, if the spouse otherwise becomes eligible for medical assistance, as specified in regulations promulgated under 42 U.S.C. 1396p(c)(4) by the Secretary of Health and Human Services. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-1.1; filed May 1, 1995, 10:45 a.m.: 18 IR 2223; errata filed Jun 9, 1995, 2:30 p.m.: 18 IR 2796; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 13, 2002, 10:09 a.m.: 25 IR 2472)*

405 IAC 2-3-1.2 Transfers involving annuities

Authority: IC 12-8-1-9; IC 12-8-6-5; IC 12-15-1-10
Affected: IC 12-15-4

Sec. 1.2. (a) For purposes of this section, "annuity" means a policy, certificate, contract, or other arrangement between two (2) or more parties whereby one (1) party pays a lump sum of money or other valuable consideration to the other party in return for the right to receive payments in the future.

(b) The purchase of an annuity, any instrument purporting to be an annuity, or any other arrangement that meets the definition of an annuity in subsection (a) shall be considered an uncompensated transfer of assets resulting in a penalty under section 1.1 of this rule unless the following criteria are met:

(1) The annuity is purchased from one (1) of the following:

(A) An insurance company or another commercial company that sells annuities as part of the normal course of business; or

(B) A nonprofit organization qualified under Section 501(c) of the Internal Revenue Code as amended.

(2) The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest. Payments will be considered substantially equal if the total annual payment in any year varies by five percent (5%) or less from the payment in the previous year.

(3) The annuity will return the full purchase price within the purchaser's life expectancy as determined by life expectancy tables published by the office.

(c) If an annuity complies with the criteria in subsection (b)(1) and (b)(2), but does not comply with *[subsection]* (b)(3), the uncompensated value of the transfer is the difference between the purchase price and the amount that the annuity will return within the purchaser's life expectancy. If an annuity does not comply with one (1) or more of the criteria in subsection (b)(1) or (b)(2), the uncompensated value is the entire purchase price.

(d) If an annuity is revocable or can be assigned to another person, it is considered an available resource for Medicaid eligibility purposes.

(e) This section applies to any annuity regardless of purchase date, except that the requirements in subsection (b)(1) and (b)(2) apply only to the following:

(1) Any annuity purchased on or after the later of:

(A) June 1, 2002; or

(B) the effective date of this rule.

(2) Any annuity regardless of purchase date, if the annuity is annuitized on or after the later of:

(A) June 1, 2002; or

(B) the effective date of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-1.2; filed May 1, 2002, 10:38 a.m.: 25 IR 2726)

405 IAC 2-3-2 Life care contracts

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 applicant who has entered into a life care contract with an institution whereby he has transferred his available assets to the institution in exchange for full maintenance and medical care during his lifetime in that institution is ineligible for medical assistance for the aged, blind, or disabled unless the contracting institution can prove to the county department by a complete and accurate accounting of all funds involved that it is unable to fulfill its contract obligations to the applicant. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-2; filed Mar 1, 1984, 2:31 pm: 7 IR 1018, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-4) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-3 Income of applicant or recipient (calculation)

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 3. Countable income is gross monthly income less the deductions and exclusions required to be excluded by federal and state statute or regulation and the deductions and exclusions as follows:

(1) Determination of net earned income as follows:

(A) All of the earned income of a child under fourteen (14) years of age is excluded.

(B) Up to ten dollars ($10) of earned income is disregarded if the income is received only once during the calendar quarter from a single source (infrequent) or could not be reasonably to expected (irregular). If the total amount of infrequent or irregular earned income received in a month exceeds ten dollars ($10), this disregard cannot be applied.

(C) Expenses allowed by the Internal Revenue Service shall be deducted from gross income from self-employment to determined net self-employment earnings.

(D) Sixty-five dollars ($65) of earned income per month, plus impairment-related work expenses described in 405 IAC 2-9-2(b) for individuals in the disabled category, plus one-half (½) of remaining earned income is excluded.

(2) Funds from a grant, scholarship, or fellowship, other than that excluded by federal regulations, which are designated for tuition and mandatory books and fees at an educational institution or for vocational rehabilitation or technical training purposes shall be deducted from the total of such funds.

(3) Tax refunds are excluded from income.

(4) Home energy assistance is disregarded.

(5) Up to twenty dollars ($20) of unearned income is disregarded if the income is received only once during the calendar quarter from a single source (infrequent) or could not reasonably be expected (irregular). If the total amount of infrequent or irregular unearned income received in a month exceeds twenty dollars ($20), this disregard cannot be applied.

(6) A general income disregard of fifteen dollars and fifty cents ($15.50) is deducted per month.

(7) Payments made to foster parents or licensed child caring institutions from county funds or reimbursed under Title IV-B of the Social Security Act on behalf of an applicant or recipient who is a ward of the county department shall be excluded.

(8) For an applicant or recipient of medical assistance under the blind category, an amount of his or her income, as specified

in an approved plan for achieving self-support, is disregarded for a period of time not to exceed twelve (12) months. Such a plan will be approved by the family and social services administration, if the plan is in writing and fully documents that the income to be disregarded will be used by the applicant or recipient in pursuing a bona fide activity aimed at achieving self-support.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-3; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1018, eff Apr 1, 1984; filed Jul 16, 1987, 2:00 p.m.: 10 IR 2669; errata, 11 IR 799; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1783; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3114; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-5) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-4 Income of legally responsible relatives; inclusion

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 4. The countable income of an applicant for or recipient includes income of certain legally responsible relatives in the following situations:

(1) Except as provided in subdivision (3), if the applicant or recipient is under eighteen (18) years of age and is living with his or her parent(s), his or her income includes the income of his or her parent(s).

(2) If the applicant or recipient is living with his or her spouse, his or her income includes the income of his or her spouse.

(3) Income of the parent(s) is not included if the applicant or recipient is under eighteen (18) years of age and has been approved from home and community based services under an approved waiver, in accordance with 42 U.S.C.A. 1396n, which specifies the exclusion of parental income.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-4; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1019, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1784; filed May 10, 2001, 9:20 a.m.: 24 IR 3022; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-6) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-4) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-5 Income of parents; calculation (Repealed)

Sec. 5. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-6 Income levels for immediate family of institutionalized applicant or recipient (Repealed)

Sec. 6. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-7 Available income of immediate family of institutionalized applicant or recipient (Repealed)

Sec. 7. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-8 Income eligibility of noninstitutionalized applicant or recipient (Repealed)

Sec. 8. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-9 Income eligibility of institutionalized applicant or recipient (Repealed)

Sec. 9. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-10 Spend-down eligibility

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 10. (a) As used in this section, "countable income" and "incurred medical expenses" are those found in 42 CFR 435.732 and section 3 of this rule.

(b) Any otherwise eligible applicant or recipient whose countable monthly income exceeds the applicable income limit specified in section 18 of this rule is eligible for medical assistance for that part of any month after his or her incurred medical expenses equal his or her excess income.

(c) In order to be determined eligible for medical assistance under this section, the applicant or recipient must provide to the county department, for each month in which he or she requests medical assistance, documentary verification of his or her incurred medical expenses for which he or she remains currently liable. The county department will promptly determine the date on which the applicant became eligible for medical assistance and issue the appropriate eligibility documents for the remainder of that month.

(d) If the applicant's anticipated medical expenses do not exceed his or her excess income, his or her application will be denied. Such an applicant may reapply at any time. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-10; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1021, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1785; filed Jul 25, 1995, 5:00 p.m.: 18 IR 3382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-12) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-10) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-11 Loans; inclusion as income

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. (a) A loan shall not be considered as income in the month of receipt if the written or verbal loan agreement is legally binding under state law and includes the following:

(1) the borrower's acknowledgement of an obligation to repay; and

(2) a timetable and plan for repayment; and

(3) the borrower's express intent to repay either by pledging real or personal property or anticipated income.

(b) An amount remaining in the month following the month of receipt shall be considered in determining whether the applicant or recipient is within the resource limit set forth in 470 IAC 9.1-3-1 *[Repealed filed Dec 16, 1986, 11:00 am: 10 IR 1081, eff Feb 1, 1987]. (Office of the Secretary of Family and Social Services; 405 IAC 2-3-11; filed Mar 1, 1984, 2:33 pm: 7 IR 1043, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-13) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-11) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-12 Contract sale of real property; calculation as income

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. In the determination of countable income received as a result of a contract sale of real property, the county department shall determine the amount of the monthly contractual payment, subtract all ownership expenses, and the remainder shall be counted as unearned income.

The down payment portion shall be considered a resource. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-12; filed Mar 1, 1984, 2:33 pm: 7 IR 1043, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-14) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-12) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-13 In-kind support and maintenance; inclusion as income

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 13. (a) The following definitions apply throughout this section:

(1) "In-kind support and maintenance" means any food, clothing, or shelter which is received by the applicant or recipient and his or her spouse, or by the child applicant or recipient and his or her parent(s) because someone else pays for it.

(2) "Shelter" means room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services.

(3) "Pro rata share of shelter" means the average value of monthly shelter costs divided by the number of people in the household, regardless of age.

(4) "Pro rata share of food" means the average monthly expenses for food divided by the number of people in the household, regardless of age.

(b) In-kind support and maintenance shall be considered as unearned income and shall be the actual value of food, clothing, or shelter received not to exceed one-third (1/3) of the applicable income standard in section 18 of this rule.

(c) In-kind support and maintenance for shelter or food shall not be considered if the applicant or recipient and his or her spouse, or his or her parent(s) if he or she is a child, live in someone else's household, and pay at least a pro rata share of shelter or food. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-13; filed Mar 1, 1984, 2:33 p.m.: 7 IR 1043, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1785; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-15) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-13) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-14 Resources; general

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. (a) Definitions. (1) Resources are all of the real and personal property owned by the applicant or recipient and his spouse or parent(s). Resources must be available in order to be considered in the eligibility determination. If the individual has the right, authority or ability to liquidate the property, or his share of the property, it is considered an available resource.

(2) Liquid assets are those assets that are in cash or are financial instruments which are convertible to cash.

(3) Current market value is the average price that the property can reasonably be expected to sell for on the open market in the particular geographic area involved.

(4) Equity value is the current market value minus the total amount of liens against the property. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-14; filed Dec 16, 1986, 11:00 am: 10 IR 1079, eff Feb 1, 1987; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-16) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-14) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-15 Resources; limitations and exclusions

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. (a) An applicant or recipient is ineligible for medical assistance for any month in which the total equity value of all nonexempt personal property exceeds the applicable limitation, set forth as follows, on the first day of the month:

(1) One thousand five hundred dollars ($1,500) for the applicant or recipient, including the amount determined in subsection (b), or in addition to the amount determined in subdivision (3), if applicable.

(2) Two thousand two hundred fifty dollars ($2,250) for the applicant or recipient and his or her spouse if the couple is living together, or if the most recent continuous period of institutionalization of one (1) member of the couple began prior to September 30, 1989.

(3) Twelve thousand dollars ($12,000), subject to adjustment under Section 1924(g) of the Social Security Act, as the spousal resource standard provided for in Section 1924(f)(2)(A)(i) of the Social Security Act, or a higher amount as determined under:

(A) Section 1924(f)(2)(A)(ii);

(B) Section 1924(f)(2)(A)(iii); or

(C) Section 1924(f)(2)(A)(iv);

of the Social Security Act for a community spouse as defined in Section 1924(h) of the Social Security Act.

(b) Except as provided in subdivision (3), if the applicant or recipient is under eighteen (18) years of age, his or her personal property includes the value of his or her parents' personal property in excess of the following limitations and in the following situations:

(1) If the child lives with one (1) parent, one thousand five hundred dollars ($1,500) of the parent's personal property is

excluded. If the child lives with two (2) parents, two thousand two hundred fifty dollars ($2,250) of the parents' personal property is excluded.

(2) If the child is institutionalized, one thousand five hundred dollars ($1,500) of the personal property of his or her custodial parent or two thousand two hundred fifty dollars ($2,250) of the personal property of both parents is excluded.

(3) If the child is approved for home and community based services under the waiver for persons with autism, in accordance with 42 U.S.C. 1396n, parental resources are excluded regardless of parental income.

(c) In addition to that property required to be excluded by federal statute or regulation, the following property is exempt from consideration:

(1) All household goods and personal effects.

(2) Personal property required by an individual's employer while the individual is employed.

(3) The equity value of personal property used to produce food for home consumption or used in the production of income.

(4) The value of life insurance with a total face value of one thousand four hundred dollars ($1,400) or less if provision has been made for payment of the applicant's or recipient's funeral expenses from the proceeds of such insurance. However, the one thousand four hundred dollars ($1,400) limitation shall be reduced by any amount in an irrevocable burial trust or irrevocable prepaid funeral agreement.

(5) For a period of no more than nine (9) months from the date of receipt, the proceeds or any interest earned on the proceeds of casualty insurance received as a result of damage, destruction, loss, or theft of exempt real or personal property if the applicant or recipient demonstrates that the proceeds are being used to repair or replace the damaged, destroyed, lost, or stolen exempt property.

(6) One (1) motor vehicle according to the following provisions:

(A) One (1) motor vehicle is excluded, regardless of value, if, for the applicant or recipient or other member of his or her household, the motor vehicle is:

(i) necessary for employment;

(ii) necessary for the medical treatment of a specific or regular medical problem; or

(iii) modified for operation by or transportation of a handicapped person.

(B) If no motor vehicle is excluded under clause (A), four thousand five hundred dollars ($4,500) of the current market value of one (1) motor vehicle is excluded.

(7) Burial spaces.

(8) Subject to the requirements in subsection (d), the home which is the principal place of residence of:

(A) the applicant or recipient;

(B) the spouse of the applicant or recipient;

(C) the parent(s) of the applicant or recipient;

(D) the applicant's or recipient's biological or adoptive child(ren) under eighteen (18) years of age; or

(E) the applicant's or recipient's blind or disabled biological or adoptive child(ren) eighteen (18) years of age or older.

(9) For an applicant or recipient of medical assistance under the blind category, an amount of his or her resources, as specified in an approved plan for achieving self-support, is disregarded for a period of time not to exceed twelve (12) months. Such a plan will be approved by the division of family and children in conjunction with the Indiana division of services for the blind if the plan is in writing and fully documents that the resources to be disregarded will be used by the applicant or recipient in pursuing a bona fide activity aimed at achieving self-support.

(10) Income producing real property if the income is greater than the expenses of ownership.

(d) The home exempted by subsection (c)(8) is exempt until such time as it is verified that none of the persons listed in subsection (c)(8) intends to reside there. The home is the shelter in which the person resides, the land on which the shelter is located, and related outbuildings.

(e) As a condition of eligibility for medical assistance for the aged, blind, and disabled, each applicant and recipient and his or her legally responsible relatives must sign an agreement to offer for sale or for rent all nonexempt real property that he or she or his or her legally responsible relatives own, except in those situations involving a community spouse and an institutionalized spouse, as defined in Section 1924(h) of the Social Security Act, wherein the total equity value of all resources of the couple does not exceed the sum of the institutionalized spouse's resource limitation specified in subsection (a)(1) and the community spouse resource standard, as determined under Section 1924(f)(2)(A) of the Social Security Act.

(f) If nonexempt real property is not offered for sale or for rent at current market value within thirty (30) days of written notification of medical assistance or within thirty (30) days after the agreement referenced in subsection (e) is signed, whichever

is later, the recipient shall be ineligible for medical assistance. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-15; filed Dec 16, 1986, 11:00 a.m.: 10 IR 1080, eff Feb 1, 1987; filed Jul 16, 1987, 2:00 p.m.: 10 IR 2670; errata, 11 IR 96; filed Jun 30, 1989, 5:00 p.m.: 12 IR 2048; filed Dec 15, 1989, 11:50 a.m.: 13 IR 878; filed Aug 21, 1996, 2:00 p.m.: 20 IR 13; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-17) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-15) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-16 Funeral trusts; consideration

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 30-2-10

Sec. 16. A funeral trust established under IC 30-2-10 et seq. which contains a technical defect in the documents required by IC 30-2-10-5 shall be deemed for the purposes of Medicaid eligibility to be valid as of the original date of establishment of the trust if the defect is corrected within twenty (20) days after receipt of notice from the county department of the defect. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-16; filed Dec 16, 1986, 11:00 am: 10 IR 1081; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-18) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-16) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-17 Income eligibility of institutionalized applicant or recipient with community spouse; posteligibility

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 17. (a) As used in this section, "institutionalized spouse" and "community spouse" have the meanings set forth in 42 U.S.C.A. 1396r-5(h)(1).

(b) The income eligibility of an institutionalized applicant or recipient with a community spouse shall be determined as follows:

(1) Determine the applicant's or recipient's countable income under section 3 of this rule and in accordance with income ownership provisions set forth in 42 U.S.C.A. 1396r-5(d).

(2) Subtract from the amount determined in subdivision (1) the individual income standard specified in section 18 of this rule.

(3) If the remainder calculated in subdivision (2) is zero dollars ($0) or less, the applicant or recipient is eligible for medical assistance.

(4) If the remainder calculated in subdivision (2) is greater than zero dollars ($0), the applicant or recipient is eligible if his or her estimated medical expenses exceed this remainder.

(c) If an applicant or recipient is determined eligible for medical assistance under subsection (b), posteligibility treatment of income to calculate the amount of income to be paid to the institution is determined as follows:

(1) Subtract from the applicant's or recipient's gross income determined according to ownership provisions set forth in 42 U.S.C.A. 1396r-5(b) those exclusions required by federal law.

(2) Subtract the minimum personal needs allowance of fifty dollars ($50).

(3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant or recipient's legal guardian, not to exceed thirty-five dollars ($35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.

(4) Subtract a spousal allocation equal to the community spouse's total income, in accordance with ownership provisions set forth in 42 U.S.C.A. 1396r-5(b), subtracted from the sum of nine hundred eighty-four dollars ($984), plus an excess shelter allowance determined under 42 U.S.C.A. 1396r-5(d)(4), subject to all provisions of 42 U.S.C.A. 1396r-5(d), 42 U.S.C.A. 1396r-5(e), and 42 U.S.C.A. 1396r-5(g).

(5) Subtract an allocation for each dependent family member, as defined in subsection (e), equal to one-third (⅓) of the amount by which nine hundred eighty-four dollars ($984) exceeds the family member's total income, subject to the provisions of 42 U.S.C.A. 1396r-5(d), 42 U.S.C.A. 1396r-5(e), and 42 U.S.C.A. 1396r-5(g).

(d) The spousal allocation calculated in subsection (c)(4) is deducted from the institutionalized applicant's or recipient's income only to the extent that it is actually made available to, or for the benefit of, the community spouse.

(e) "Dependent family member", for the purpose of determining the allocation in subsection (c)(5), is a person listed, as

follows, who resides with the community spouse:

(1) Biological or adoptive children of either spouse under twenty-one (21) years of age.

(2) Biological or adoptive children of the community or institutionalized spouse who are twenty-one (21) years of age or over and who are claimed for tax purposes by either spouse under the Internal Revenue Service Code.

(3) The parent(s) of the community or institutionalized spouse who are claimed as dependents by either spouse for tax purposes under the Internal Revenue Service Code.

(4) Biological and adoptive siblings of the community or institutionalized spouse who are claimed by either spouse for tax purposes under the Internal Revenue Service Code.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-17; filed Dec 1, 1989, 5:00 p.m.: 13 IR 628; filed May 2, 1990, 4:55 p.m.: 13 IR 1707; filed Aug 9, 1991, 11:00 a.m.: 14 IR 2227; filed May 14, 1992, 5:00 p.m.: 15 IR 2191; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1785; filed Feb 23, 1998, 11:30 a.m.: 21 IR 2383; filed Feb 7, 2000, 3:26 p.m.: 23 IR 1377; errata filed Mar 20, 2000, 3:19 p.m.: 23 IR 2003; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-19) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-17) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-18 Income standards

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

Sec. 18. (a) The standards used in determining the income eligibility of an applicant or recipient under sections 17 and 20 of this rule are as follows:

(1) Individual standard, four hundred seventy dollars ($470).

(2) Couple standard, seven hundred five dollars ($705).

(3) Nonapplicant or nonrecipient dependent child standard, two hundred thirty-five dollars ($235).

(4) Applicant or recipient dependent child standard, four hundred seventy dollars ($470).

(5) Essential person standard, two hundred thirty-five dollars ($235).

(6) One (1) parent standard, four hundred seventy dollars ($470).

(7) Two (2) parent standard, seven hundred five dollars ($705).

(8) Stepparent standard, two hundred thirty-five dollars ($235).

(b) Beginning in calendar year 1997, the income standards specified in subsection (a) shall increase annually in the same percentage amount that is applied to Supplemental Security Income (SSI) benefits under 42 U.S.C. 1382(f). The increase in the income standards shall be effective on the first day of the same month in which the division of family and children processes the Title II costs of living adjustments received by public assistance recipients under 42 U.S.C. 415(i). *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-18; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1786; filed Jul 18, 1994, 11:00 a.m.: 17 IR 2853; filed Jun 15, 1995, 10:00 a.m.: 18 IR 2760; filed Aug 21, 1996, 2:00 p.m.: 20 IR 15; filed Feb 12, 1997, 4:00 p.m.: 20 IR 1734; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 2-3-19 Income deemed from parents

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 19. (a) Except as provided in section 4 of this rule, the amount of income of a parent(s) to be included as income to an applicant or recipient in section 20 of this rule is determined according to the following procedures:

(1) Determine the unearned income of the parent(s) which is not excluded by state or federal statute or regulation.

(2) If the stepparent of the applicant or recipient is living in the home of the applicant or recipient and his or her parent, subtract an allocation from the income of the parent as determined under subsection (b).

(3) Subtract an allocation to dependent children as determined under subsection (b).

(4) Subtract the general income disregard specified in section 3 of this rule. The resulting amount is countable unearned income.

(5) Determine the earned income of the parent(s).

(6) Subtract any remaining allocation to dependent children as determined under subsection (b).

(7) Subtract any remaining amount of the general income disregard.

(8) Subtract the earned income disregard specified in section 3 of this rule. The resulting amount is countable earned income.

(9) Combine countable unearned and countable earned income.

(10) Subtract the appropriate parental income standard specified in section 18 of this rule.

(11) The resulting amount is deemed as income to the applicant or recipient.

(b) An allocation equal to the individual's income subtracted from the applicable income standard in section 18 of this rule shall be subtracted first from unearned income and then from earned income for the following individuals:

(1) The applicant's or recipient's stepparent and the stepparent's dependent children who are not receiving assistance to families with dependent children. The allocation shall not exceed the stepparent standard specified in section 18 of this rule.

(2) A nonapplicant or nonrecipient dependent child of the parent(s), if the child is not receiving adoption assistance or assistance to families with dependent children. The allocation shall be subtracted from the income of the child's biological or adoptive parent(s).

(c) An allocation is not subtracted if the individual's income equals or exceeds the applicable income standard. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-19; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1787; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 2-3-20 Income eligibility of applicant or recipient

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 20. (a) Except as provided in section 17 of this rule, an applicant's or recipient's income eligibility shall be determined by the following procedures:

(1) Determine the applicant's or recipient's unearned income which is not excluded by state or federal statute or regulation.

(2) Add to the amount determined in subdivision (1) the amount of the spouse's unearned income after subtracting any allocation to a dependent child of the spouse as provided in subsection (b).

(3) Add to the amount determined in subdivision (1) any deemed income from a parent as determined under section 19 of this rule.

(4) Subtract the general income disregard specified in section 3 of this rule.

(5) Subtract any allocation as determined under subsection (b). The resulting amount is countable unearned income.

(6) Determine the earned income of the applicant or recipient.

(7) Add the spouse's earned income after subtracting any remaining allocation to a dependent child from subdivision (2).

(8) Subtract any remaining general income disregard.

(9) Subtract the remaining allocations as determined under subsection (b).

(10) Subtract the earned income disregard specified in section 3 of this rule. The resulting amount is countable earned income.

(11) Combine countable unearned and countable earned income.

(12) Subtract the individual income standard specified in section 18 of this rule if the applicant or recipient is not living with a spouse or is living with a spouse who is receiving assistance to families with dependent children.

(13) Subtract the couple income standard specified in section 18 of this rule if the applicant or recipient is living with a spouse who is not receiving assistance to families with dependent children.

(14) If the resulting amount in subdivision (12) or (13) is zero dollars ($0) or less than zero dollars ($0), the applicant or recipient is eligible for medical assistance. If the resulting amount is greater than zero dollars ($0), the applicant or recipient is eligible if he or she meets the requirements of section 10 of this rule.

(b) An allocation equal to the individual's income subtracted from the applicable income standard in section 18 of this rule shall be subtracted first from unearned income and then from earned income for the following individuals:

(1) A dependent child of the spouse of an applicant or recipient if the child is not receiving adoption assistance or assistance to families with dependent children.

(2) A nonapplicant or nonrecipient dependent child of the applicant or recipient if the child is not receiving adoption assistance or assistance to families with dependent children.

(3) An applicant or recipient child of the applicant or recipient.

(4) One (1) essential person of the applicant or recipient if the essential person is not receiving assistance to families with dependent children.

(c) An allocation is not subtracted if the individual's income equals or exceeds the applicable income standard. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-20; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1787; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 2-3-21 Posteligibility income calculation

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 21. Except as provided in section 17 of this rule, the following procedures are used to determine the amount of income to be paid to an institution for an applicant or recipient who has been determined eligible under section 20 of this rule and who is residing in a Title XIX certified hospital, nursing facility, intermediate care facility for the mentally retarded, or public institution:

(1) Determine the applicant's or recipient's total income which is not excluded by federal statute. Total income includes amounts deducted in the eligibility determination under section 20 of this rule.

(2) Subtract the minimum personal needs allowance of fifty dollars ($50).

(3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant or recipient's legal guardian, not to exceed thirty-five dollars ($35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.

(4) Subtract the amount of health insurance premiums.

(5) Subtract an amount for expenses incurred for necessary medical or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.

(6) The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-21; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788; filed Feb 23, 1998, 11:30 a.m.: 21 IR 2384; filed Feb 7, 2000, 3:26 p.m.: 23 IR 1378; errata filed Mar 20, 2000, 3:19 p.m.: 23 IR 2003; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 2-3-22 Trusts

Authority: IC 12-13-5-3; IC 12-15-1-10
Affected: IC 12-15-2-17; IC 12-15-3

Sec. 22. (a) This section governs the treatment of trusts when determining eligibility of an applicant or recipient of Medicaid. This section applies to trusts established by an applicant or recipient of Medicaid as defined in subsection (e). As used in this section, "individual" means an applicant or recipient of Medicaid.

(b) A revocable trust established by an applicant or recipient shall be considered as follows:

(1) The corpus of the trust shall be considered resources available to the individual.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual for purposes of section 1.1 of this rule.

(c) An irrevocable trust established by an applicant or recipient shall be considered as follows:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus or income from which payment to the individual could be made shall be considered resources available to the individual. Payments from that portion of the corpus or income shall be counted as follows:

(A) Payments to or for the benefit of the individual shall be considered income of the individual.

(B) Payments for any other purpose shall be considered assets disposed of by the individual subject to section 1.1 of this rule.

(2) If there are no circumstances under which payment from a portion of the trust could be made to or for the benefit of the individual, the portion of the corpus or income from which no payment to the individual could be made shall be considered to be assets disposed of by the individual for purposes of section 1.1 of this rule. For purposes of section 1.1 of this rule, the following shall apply:

(A) The assets shall be considered disposed of as of the date of establishment of the trust or the date on which payment to the individual was foreclosed, whichever is later.

(B) The value of the trust shall be determined by including the amount of any payments made from that portion of the trust after the date in clause (A).

(d) As used in this section, "trust" includes, but is not limited to, any legal instrument or device that is similar to a trust. The term includes an annuity only to such extent and in such manner as allowed by regulations of the Secretary of Health and Human Services.

(e) For purposes of this section, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust, and if any of the following individuals established the trust other than by will:

(1) The individual.

(2) The individual's spouse.

(3) A person with legal authority to act in place of or on behalf of the individual or the individual's spouse, including, but not limited to, a court or administrative body.

(4) A person acting at the direction or upon the request of the individual or the individual's spouse, including, but not limited to, a court or administrative body.

(f) As used in this section, "assets" includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action:

(1) by the individual or the individual's spouse;

(2) by a person with legal authority to act in place of or on behalf of the individual or the individual's spouse, including, but not limited to, a court or administrative body; or

(3) by a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(g) In the case of a trust, the corpus of which includes assets of an individual and assets of any other person or persons, this subsection shall apply to that portion of the trust attributable to the assets of the individual.

(h) Subject to subsection (i), this subsection shall apply without regard to any of the following:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distributions may be made from the trust.

(4) Any restrictions on the use of distributions from the trust.

(i) This section shall not apply to any of the following trusts:

(1) A trust containing the assets of an individual under sixty-five (65) years of age who is disabled as defined in 42 U.S.C. 1382c(a)(3), and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court, if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

(2) A trust composed only of:

(A) pension;

(B) Social Security;

(C) other income of the individual; and

(D) accumulated income in the trust;

if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

(3) A trust containing the assets of an individual who is disabled as defined in 42 U.S.C. 1382c(a)(3) that meets the following conditions:

(A) The trust is established and managed by a nonprofit association.

(B) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(C) Accounts in the trust are established solely for the benefit of individuals who are disabled by:

(i) the parent, grandparent, or legal guardian of the individuals;

(ii) the individuals; or

(iii) a court.

(D) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount

of medical assistance paid on behalf of the beneficiary.

(j) The office may waive the application of this section in cases of undue hardship, but only to the extent required by standards specified under 42 U.S.C. 1396p(d)(5) by the Secretary of Health and Human Services.

(k) This section applies to trusts established on or after August 11, 1993. Trusts established before August 11, 1993, are governed by 42 U.S.C. 1396a(k). *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-22; filed May 1, 1995, 10:45 a.m.: 18 IR 2225; errata filed Jun 9, 1995, 2:30 p.m.: 18 IR 2796; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 3.1. Eligibility Requirements Based on Need; Pregnancy-Related Coverage; Coverage for Children 18 Years of Age and Under (Voided)

NOTE: Voided by P.L.119-1997, SECTION 6, effective April 9, 1997.

Rule 4. Burial Expenses

405 IAC 2-4-1 Payment of burial expenses

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) For the purpose of implementing the provisions of IC 12-1-5-11 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*, IC 12-1-6-11 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*, and IC 12-1-7.1-13 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*, a recipient of medical assistance for the aged, blind, and disabled is that person who is receiving medical assistance as of the date of his death, or who applied for medical assistance prior to the date of his death and was subsequently determined eligible.

(b) The state department shall pay for the cost of the deceased recipient's burial expenses subject to the following limitations:

(1) Payment will be made only to the funeral director or cemetery representative upon submission of a completed claim form prescribed by the state department.

(2) Payment shall not be made to a funeral director who submits a claim for cemetery expenses unless he attaches proof to the claim that he is the cemetery representative or has been designated the cemetery representative.

(3) In determining the amount to be paid by the state department to the funeral director, contributions paid and payments made or available from the estate of the deceased recipient in excess of the exclusion provided by IC 12-1-5-11 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*, IC 12-1-6-11 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*, and IC 12-1-7.1-13 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* shall be subtracted from the statutory maximum. The balance of the unpaid expenses, up to the statutory maximum, shall be paid by the state department.

(4) In determining the amount to be paid by the state department to the cemetery representative, contributions paid and payments made or available from the estate of the deceased recipient in excess of the statutory exclusion shall be subtracted from the statutory maximum. The balance of the unpaid expenses, up to the statutory maximum, shall be paid by the state department.

(Office of the Secretary of Family and Social Services; 405 IAC 2-4-1; filed Mar 1, 1984, 2:31 pm: 7 IR 1021, eff Apr 1, 1984; errata, 7 IR 1254; filed Aug 2, 1985, 2:39 pm: 8 IR 2023, eff Sep 1, 1985; filed Jul 16, 1987, 2:00 pm: 10 IR 2671; errata, 11 IR 799; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-4-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-4-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

Rule 5. Determination of Monthly Income

405 IAC 2-5-1 Conversion of income

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4
Affected: IC 12-14; IC 12-15

Sec. 1. (a) When determining eligibility and the amount of assistance payment for the months beginning with the month of

application, the following computations shall be made to establish income for the payment month:

(1) Income received on a less than monthly basis shall be converted to a monthly amount as follows:

(A) Income received weekly shall be multiplied by four and three-tenths (4.3) to determine the monthly income.

(B) Income received every two (2) weeks shall be multiplied by two and fifteen-hundredths (2.15) to determine the monthly income.

(C) Income received twice per month shall be multiplied by two (2) to determine the monthly income.

(2) Income which is not expected to continue throughout the payment month shall be considered in the actual amount anticipated to be received in that month.

(3) Income received on a contractual basis shall be prorated over the number of months covered under the contract, and the resultant amount shall be considered available monthly income.

(4) Income received on a quarterly, semiannual, or annual basis shall be divided by the appropriate number of months to establish a monthly amount.

(5) Income received to defray the cost of education shall be prorated over the period intended to be covered by the income.

(6) Fluctuating income may be averaged to determine a monthly amount.

(b) In determining eligibility for months prior to the month of application, the actual amount of income received shall be considered income. *(Office of the Secretary of Family and Social Services; 405 IAC 2-5-1; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1778; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 6. Medical Assistance for Individuals 18, 19, and 20 Years of Age

405 IAC 2-6-1 Medical assistance for individuals 18, 19, and 20 years of age

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4
Affected: IC 12-14; IC 12-15

Sec. 1. (a) An individual eighteen (18), nineteen (19), or twenty (20) years of age who meets the criteria established in 42 CFR 435.220, as revised and effective on October 1, 1991, is eligible for medical assistance.

(b) The income eligibility determination for such person shall be based upon those income standards established for the assistance to families with dependent children program in accordance with 470 IAC 10.1-3-3 *[470 IAC 10.1-3-3 was repealed filed Aug 26, 1987, 11:00 a.m.: 11 IR 90. See 470 IAC 10.1-3-3.1]*.

(c) The budgeting methodologies established for the assistance to families with dependent children program in accordance with 470 IAC 10.1-3-4 shall apply to this rule.

(d) The income and resources of the applicant or recipient and that of his or her parents living in the home with the applicant or recipient are considered in determining the individual's eligibility. *(Office of the Secretary of Family and Social Services; 405 IAC 2-6-1; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1779; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 7. Medical Assistance for Individuals Receiving Supplemental Security Income Benefits

405 IAC 2-7-1 Definitions

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4
Affected: IC 12-14; IC 12-15

Sec. 1. (a) As used in this rule, "dependent child" means a child under eighteen (18) years of age, who meets the conditions of 45 CFR 233.90, as revised and effective on October 1, 1991, (not including tertiary Code of Federal Regulations citations resulting therefrom) or 45 CFR 233.100, as revised and effective on October 1, 1991, (not including tertiary Code of Federal Regulations citations resulting therefrom).

(b) As used in this rule, "caretaker" means a relative as defined in 45 CFR 233.90, as revised and effective on October 1, 1991, (not including tertiary Code of Federal Regulations citations resulting therefrom) who has a specified degree of relationship to and assumes the primary responsibility for a dependent child. *(Office of the Secretary of Family and Social Services; 405 IAC 2-7-1; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1779; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 2-7-2 Medical assistance for supplemental security income recipients

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4
Affected: IC 12-14; IC 12-15

Sec. 2. (a) Supplemental security income recipients who meet the criteria established in 42 CFR 435.210, as revised and effective on October 1, 1991, (not including tertiary Code of Federal Regulations citations resulting therefrom) are eligible for medical assistance.

(b) The income and resources of the following individuals are considered in the eligibility determination:

(1) The supplemental security income recipient.

(2) His or her spouse, if the supplemental security income recipient is a caretaker.

(3) His or her parent, if the supplemental security income recipient is a dependent child.

(c) The income eligibility determination for such person shall be based upon those income standards established for the assistance to families with dependent children program in accordance with 470 IAC 10.1-3-3 *[470 IAC 10.1-3-3 was repealed filed Aug 26, 1987, 11:00 a.m.: 11 IR 90. See 470 IAC 10.1-3-3.1]*.

(d) The budgeting methodology established for the assistance to families with dependent children program in accordance with 470 IAC 10.1-3-4 shall apply to this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 2-7-2; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1779; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 8. Claims Against Estate of Medicaid Recipients

405 IAC 2-8-1 Claims against estate for benefits paid

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-15-1-10; IC 12-15-9-6
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 1. (a) Upon the death of a Medicaid recipient fifty-five (55) years of age or older, the office of Medicaid policy and planning (office) shall seek recovery from the recipient's estate for medical assistance paid on behalf of the recipient after the recipient became fifty-five (55) years of age or older. Recovery shall be made for benefits provided prior to October 1, 1993, only if the recipient was sixty-five (65) years of age or older at the time the benefits were provided.

(b) As used in this section, "estate", with respect to a deceased recipient, shall include all real and personal property and other assets included within the recipient's estate as defined for purposes of state probate law.

(c) If the recipient is survived by a spouse, recovery shall be made after the death of the surviving spouse. Only those assets that are included in the recipient's estate as defined in subsection (b) are subject to recovery.

(d) If the recipient is survived by a child, no recovery shall be made while the child is either:

(1) under twenty-one (21) years of age; or

(2) blind or disabled as defined in 42 U.S.C. 1382c.

(e) A claim may not be enforced against the following assets:

(1) Personal effects, ornaments, or keepsakes of the deceased.

(2) Assets of an individual who purchases a long term care insurance policy that are disregarded pursuant to IC 12-15-3-6.

(f) The office may waive the application of this section in cases of undue hardship pursuant to section 2 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 2-8-1; filed May 1, 1995, 10:45 a.m.: 18 IR 2226; filed Feb 15, 1996, 11:20 a.m.: 19 IR 1563; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 2-8-2 Undue hardship

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-15-1-10; IC 12-15-9-6
Affected: IC 12-15-9; IC 29-1-14-9

Sec. 2. (a) The office may waive the enforcement of the state's claim, in whole or in part, if enforcement of the state's claim will result in substantial and undue hardship for the surviving beneficiaries of the decedent's estate. The state's claim is suspended as long as the undue hardship condition continues to exist.

(b) For the purposes of this section, undue hardship exists only if enforcement of the state's claim would result in one (1) or more of the following conditions:

(1) Causing a beneficiary of the decedent's estate to become eligible for public assistance. As used in this section, "public assistance" means Aid to Families with Dependent Children, Medicaid, food stamps, or Supplemental Security Income.

(2) Causing a beneficiary of the decedent's estate who is currently eligible for public assistance to remain dependent on that public assistance.

(3) The complete loss of an income-producing asset or assets when the beneficiary of the decedent's estate has no other source of income and the beneficiary's income does not exceed one hundred percent (100%) of the poverty level as determined annually by the U. S. Department of Health and Human Services.

(4) Other compelling circumstances as determined on a case-by-case basis by the office. Undue hardship does not exist in circumstances where the state's recovery simply results in a loss of a preexisting standard of living.

(c) To be eligible for consideration for an undue hardship waiver, the beneficiary of the decedent's estate must, with the exception noted in this subsection, be a member of the immediate family of either the deceased recipient or the deceased recipient's spouse. For purposes of this section, "immediate family" is defined as a spouse, child, grandchild, great-grandchild, parent, grandparent, brother, or sister. In exceptional circumstances, if good cause is shown, a person other than an immediate family member may be eligible for consideration for an undue hardship waiver.

(d) The office shall notify the executor or personal representative of the deceased Medicaid recipient's estate of the state's claim against the estate and the affected beneficiary's right to apply for an undue hardship waiver. Application for an undue hardship waiver shall be submitted to the office on such forms as may be designated by the secretary and shall include all of the following information:

(1) The name of the deceased recipient.

(2) The name of the person filing the application.

(3) The relationship of the applicant to the deceased.

(4) An explanation of the basis for requesting an undue hardship waiver.

(5) Documentation of the existence of one (1) or more of the conditions described in subsection (b).

(6) Other information as may be deemed necessary by the secretary.

Such application shall include a statement attesting to the accuracy of the information contained in the application and be signed by the applicant. Applications for an undue hardship waiver shall be filed with the office within ninety (90) calendar days of the date that the executor or personal representative of the deceased's estate receives notification of the state's claim.

(e) The office shall review and rule on an application for a waiver of the state's claim within forty-five (45) calendar days of the receipt of a properly completed waiver application.

(f) If the office determines that an undue hardship does not exist, the office shall notify the applicant of its decision in writing and shall inform the applicant of his or her right to request an administrative hearing and the procedures for filing an appeal. An appeal and request for hearing must be filed within thirty (30) days of receipt of the office's decision that an undue hardship waiver has been denied.

(g) The office may not grant an undue hardship waiver if the granting of such waiver will result in the payment of claims to other creditors with a lower priority standing in accordance with IC 29-1-14-9.

(h) The office may deny an undue hardship waiver if the granting of such waiver will not result in the abatement of the undue hardship. *(Office of the Secretary of Family and Social Services; 405 IAC 2-8-2; filed Feb 15, 1996, 11:20 a.m.: 19 IR 1564; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 9. Medicaid for Employees with Disabilities

405 IAC 2-9-1 Purpose and general eligibility requirements

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15
Affected: IC 12-15-2-6.5; IC 12-15-3-1; IC 12-15-3-2; IC 12-15-41

Sec. 1. (a) This rule establishes the eligibility requirements for the two (2) optional Medicaid categories for Employees with Disabilities identified in 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI), and in accordance with the provisions of IC 12-15-41.

(b) As used in this rule, "applicant or recipient" means an individual whose Medicaid eligibility is being determined under one (1) of the above referenced Medicaid categories and in accordance with the requirements of this rule.

(c) A person who is less than sixteen (16) years of age, or age sixty-five (65) or older is not eligible for Medicaid for

employees with disabilities.

(d) A recipient must report any change in income, resources, employment status, or marital status within ten (10) days of the date of the change. An additional ten (10) days is allowed to provide any necessary verification.

(e) A disabled individual will be considered for eligibility under this rule if the individual is ineligible for Medicaid under the disability category for any of the following reasons:

(1) The individual's income exceeds the applicable standard specified in IAC 2-3-18 *[sic., 405 IAC 2-3-18]*.

(2) The individual's resources exceed the limit in IC 12-15-3-1 or IC 12-15-3-2.

(3) The individual's gross earnings exceed the substantial gainful activity amount established by the Social Security Administration in 20 CFR 416.974.

(f) In addition to the requirements in this rule, the requirements in the following rules apply to applicants and recipients of Medicaid for employees with disabilities:

(1) 405 IAC 2-1-2.
(2) 405 IAC 2-1-3.
(3) 405 IAC 2-2-4.
(4) 405 IAC 2-3-1.1.
(5) 405 IAC 2-3-2.
(6) 405 IAC 2-3-11.
(7) 405 IAC 2-3-12.
(8) 405 IAC 2-3-13.
(9) 405 IAC 2-3-14.
(10) 405 IAC 2-3-22.
(11) 405 IAC 2-4-1.
(12) 405 IAC 2-5-1.
(13) 405 IAC 2-8-1.
(14) 405 IAC 2-8-2.

(Office of the Secretary of Family and Social Services; 405 IAC 2-9-1; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3115)

405 IAC 2-9-2 Income of applicant or recipient

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15
Affected: IC 12-15-2-6.5; IC 12-15-41

Sec. 2. (a) Countable income is gross monthly income less the deductions and exclusions required by federal or state statute or regulation and the deductions and exclusions in this section.

(b) The following are disregarded or deducted in determining net earned income:

(1) Up to ten dollars ($10) of earned income is disregarded if the income is either infrequent or irregular. Infrequent income is income received only once during the calendar quarter from a single source. Irregular income is income that could not reasonably be expected. If the total amount of infrequent or irregular earned income received in a month exceeds ten dollars ($10), this disregard cannot be applied.

(2) Expenses allowed by the Internal Revenue Service shall be deducted from gross income from self-employment to determine net self-employment earnings.

(3) Sixty-five dollars ($65) of earned income per month, plus impairment-related work expenses described in *[subdivision]* (4) below, plus one-half (½) of remaining earned income is excluded.

(4) Impairment-related work expenses are expenses that are paid by the applicant or recipient for the purchase or rental of certain items and services that are necessary, due to the severity of his or her impairment, in order for the applicant or recipient to work. No deduction is allowed if the expense has been, could be, or will be paid by another source or if the applicant or recipient will be reimbursed by another source, including, but not limited to, Medicaid, Medicare, private health insurance, or another agency. Allowable impairment-related expenses are listed below:

(A) Payments for attendant care services in the following circumstances:

(i) Because of the applicant's or recipient's impairment, he or she needs assistance in traveling to and from work, or while at work needs assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating).

(ii) Because of the applicant's or recipient's impairment, assistance is needed at home with personal functions (e.g., dressing, administering medications) in preparation for going to and returning from work.

(iii) Payments made to a family member for attendant care services will be allowed only if the family member suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked in order to perform the services.

(iv) A family member is anyone who is related to the applicant or recipient by blood, marriage, or adoption, whether or not that person lives with the applicant or recipient.

(v) If only part of the payment to a person is for services that come under the provisions of items (i) and (ii), only the portion attributable to those services will be allowed.

(B) Payments for medical devices. If the impairment requires the applicant or recipient to utilize medical devices in order to work, the payments made for those devices may be deducted. As used in this subparagraph *[clause]*, medical devices include durable medical equipment that can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators, and pacemakers.

(C) Payments for prosthetic devices. If the impairment requires the applicant or recipient to utilize a prosthetic device in order to work, the payments made for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs, and other parts of the body.

(D) Payments for work-related equipment. If the impairment requires the applicant or recipient to utilize special equipment in order to do his or her job, the payments made for that equipment may be deducted.

(E) Payments for residential modifications. If the impairment requires the applicant or recipient to make modifications to his or her place of residence, the location of the workplace will determine if the cost of these modifications will be deducted. If the applicant or recipient is employed away from home, only the cost of changes made outside of the home to permit the applicant or recipient to get to his or her means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of the home will not be deducted if the person works away from home. If the applicant or recipient works at home, the costs of modifying the inside of the home in order to create a working space to accommodate his or her impairment will be deducted to the extent that the changes pertain specifically to the space in which he or she works. Examples of such changes are the enlargement of a doorway leading into the work space or modification of the work space to accommodate problems in dexterity. However, if the applicant or recipient is self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(F) Payments for transportation costs in the following circumstances are allowed:

(i) The impairment requires that in order for the applicant or recipient to get to work, a vehicle that has structural or operational modifications is required. The modifications must be critical to the applicant's or recipient's operation or use of the vehicle and directly related to his or her impairment. The costs of the modifications will be deducted, but not the cost of the vehicle. A mileage allowance for the trip to and from work will be allowed in the same amount as allowed by the Supplemental Security Income program for this purpose.

(ii) The impairment requires the applicant or recipient to use driver assistance, taxicabs or other hired vehicles in order to work. Amounts paid to the driver and, if the applicant's or recipient's own vehicle is used, a mileage allowance will be deducted for the trip to and from work.

(iii) The impairment prevents the applicant or recipient from taking available public transportation to and from work and he or she must drive his or her (unmodified) vehicle to work. A mileage allowance for the trip to and from work will be deducted if verification is obtained through the applicant's or recipient's physician or other sources that the need to drive is caused by the impairment, and not due to the unavailability of public transportation.

(G) All other impairment-related expenses allowed by the Supplemental Security Income program.

(c) Funds from a grant, scholarship, or fellowship that are designated for tuition and mandatory books and fees at an educational institution or for vocational rehabilitation or technical training purposes shall be deducted from the total of such funds except as prohibited by federal regulations.

(d) Tax refunds are excluded from income.

(e) Home energy assistance is disregarded.

(f) Up to twenty dollars ($20) of unearned income is disregarded if the income is either infrequent or irregular. Infrequent income is income received only once during the calendar quarter from a single source. Irregular income is income that could not reasonably be expected. If the total amount of infrequent or irregular unearned income received in a month exceeds twenty dollars ($20), this disregard cannot be applied.

(g) A general income disregard of fifteen dollars and fifty cents ($15.50) is deducted per month.

(h) Payments made to foster parents or licensed child caring institutions from county funds or reimbursed under Title IV-B of the Social Security Act on behalf of an applicant or recipient who is a ward of the county department are excluded.

(i) Income of the spouse of the applicant or recipient is excluded.

(j) Income of the parents of the applicant or recipient is excluded. *(Office of the Secretary of Family and Social Services; 405 IAC 2-9-2; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3116)*

405 IAC 2-9-3 Income eligibility and posteligibility determinations of applicant or recipient

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15
Affected: IC 12-15-2-6.5; IC 12-15-7-2; IC 12-15-41

Sec. 3. (a) An applicant's or recipient's income eligibility shall be determined by the following procedures:

(1) Determine the applicant's or recipient's unearned income which is not excluded by state or federal statute or regulation.

(2) Subtract the general income disregard specified in section 2 of this rule. The resulting amount is countable unearned income.

(3) Determine the earned income of the applicant or recipient.

(4) Subtract any remaining general income disregard.

(5) Subtract the earned income disregard(s) specified in section 2 of this rule. The resulting amount is countable earned income.

(6) Combine countable unearned and countable earned income.

(7) Subtract the monthly income standard that is equal to three hundred fifty percent (350%) of the federal poverty guideline for a family size of one (1), divided by twelve (12) and rounded up to the next whole dollar.

(8) If the resulting amount in *[subdivision]* (7) is zero dollars ($0) or less than zero dollars ($0), the applicant or recipient is eligible for Medicaid for employees with disabilities. If the resulting amount is greater than zero dollars ($0), the applicant or recipient is not eligible.

(b) The income standard referenced in *[subsection]* (a)(7) shall be increased annually beginning the second month following the month in which the federal poverty guidelines are published in the Federal Register.

(c) The following procedures are used to determine the amount of income to be paid to an institution for an applicant or recipient who has been determined eligible under subsection (a) of this section and who is residing in a Title XIX certified health care facility:

(1) Determine the applicant's or recipient's total income which is not excluded by federal statute. Total income includes amounts deducted in the eligibility determination under subsection (a).

(2) Subtract the minimum personal needs allowance specified in IC 12-15-7-2.

(3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant's or recipient's legal guardian, not to exceed thirty-five dollars ($35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.

(4) Subtract the amount of health insurance premiums.

(5) Subtract an amount for expenses incurred for necessary medical or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.

(6) The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

(Office of the Secretary of Family and Social Services; 405 IAC 2-9-3; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3117; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769)

405 IAC 2-9-4 Resource eligibility of applicant or recipient

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15
Affected: IC 12-15-2-6.5; IC 12-15-41-2

Sec. 4. (a) An applicant or recipient is ineligible for Medicaid for employees with disabilities for any month in which the total equity value of all nonexempt personal property owned by the applicant and his or her spouse exceeds the applicable limitation for a single individual or married couple as prescribed by the Supplemental Security Income program.

(b) The resources of the applicant's or recipient's parents are excluded.

(c) In addition to that property required to be excluded by federal statute or regulation, the following property is exempt from consideration:

(1) All household goods and personal effects.

(2) Personal property required by an individual's employer while the individual is employed.

(3) The equity value of personal property used to produce food for home consumption or used in the production of income.

(4) The value of life insurance with a total face value of ten thousand dollars ($10,000) or less if provision has been made for payment of the applicant's or recipient's funeral expenses from the proceeds of such insurance. However, the ten thousand dollar ($10,000) limitation shall be reduced by any amount in an irrevocable burial trust or irrevocable prepaid funeral agreement.

(5) For a period of no more than nine (9) months from the date of receipt, the proceeds or any interest earned on the proceeds of casualty insurance received as a result of damage, destruction, loss, or theft of exempt real or personal property if the applicant or recipient demonstrates that the proceeds are being used to repair or replace the damaged, destroyed, lost, or stolen exempt property.

(6) One (1) motor vehicle according to the following provisions:

(A) One (1) motor vehicle is excluded, regardless of value, if, for the applicant or recipient or other member of his or her household, the motor vehicle is:

(i) necessary for employment;

(ii) necessary for the medical treatment of a specific or regular medical problem; or

(iii) modified for operation by or transportation of a handicapped person.

(B) If no motor vehicle is excluded under clause (A), four thousand five hundred dollars ($4,500) of the current market value of one (1) motor vehicle is excluded.

(7) Burial spaces.

(8) Subject to the requirements in subsection (d), the home which is the principal place of residence of:

(A) the applicant or recipient;

(B) the spouse of the applicant or recipient;

(C) the parent of the applicant or recipient who is under age 18;

(D) the applicant's or recipient's biological or adoptive child under eighteen (18) years of age; or

(E) the applicant's or recipient's blind or disabled biological or adoptive child eighteen (18) years of age or older.

(9) Income producing real property if the income is greater than the expenses of ownership.

(10) Up to twenty thousand dollars ($20,000), as approved by the central office of the family and social services administration, for an independence and self-sufficiency account defined in IC 12-15-41-2(3). A resource disregard for this purpose will be approved if the applicant or recipient submits a plan in writing to the local office of family and children caseworker that describes specifically the goods and or services that he or she intends to purchase that will increase, maintain, or retain his or her employability or independence. The items must be reasonable in terms of the applicant's or recipient's ability to achieve a stated goal which is focused on the individual's employability by removing barriers. Items for personal recreational use will not be approved. A request to save money without specifying goods or services to be purchased within an achievable period of time will not be approved. An approved account will be reviewed by the local office of family and children caseworker at each annual redetermination. If the terms of the original approved account have not been met, the recipient will be required to submit an updated request to the caseworker within thirty (30) days of receiving written notification from the caseworker that such an update is required. If the recipient fails to submit the update, the disregard will be disapproved and resource eligibility will be redetermined without it. The caseworker will forward updates to the central office for approval. At any time during the period of eligibility under the Medicaid for employees with disabilities program, the recipient may submit an update requesting an adjustment in the approved amount. Approval will not be given for any

services that are available to the recipient under Medicaid or any other publicly funded program.

(11) Retirement accounts held by the applicant or recipient or his or her spouse are exempt. This includes Individual Retirement Accounts, Keogh Plans, 401(k), 403(b), and 457 plans, and any employer-related retirement account.

(d) The home exempted by subsection (c)(8) is exempt until such time as it is verified that none of the persons listed in subsection (c)(8) intends to reside there. The home is the shelter in which the person resides, the land on which the shelter is located, and related outbuildings.

(e) As a condition of eligibility for Medicaid for employees with disabilities, an applicant or recipient and his or her spouse must sign an agreement to offer for sale or for rent all nonexempt real property that he or she or his or her spouse own.

(f) If nonexempt real property is not offered for sale or for rent at current market value within thirty (30) days of written notification of medical assistance or within thirty (30) days after the agreement referenced in subsection (e) is signed, whichever is later, the recipient shall be ineligible. *(Office of the Secretary of Family and Social Services; 405 IAC 2-9-4; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3118)*

405 IAC 2-9-5 Employment requirements; continuing eligibility when employment ends

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15
Affected: IC 12-15-2-6.5; IC 12-15-41

Sec. 5. (a) In order for an individual to be eligible for Medicaid for employees with disabilities, the individual must be engaged in a substantial and reasonable work effort. This means that the person must be either employed or self-employed, with the intent of such work activity being ongoing. Employment must be verifiable by pay stubs or other verification from an employer documenting that the income is subject to income tax and FICA withholding. Self-employment must be verified by the individual's income tax return, or in the case of a new business for which a tax return has not yet been filed, the personal business records of the individual.

(b) In order for a recipient of Medicaid for employees with disabilities to remain eligible when the definition of medically improved disability in 405 IAC 2-9-7 *[section 7 of this rule]* is met, the recipient must be employed as defined in *[subsection]* (a) and must have monthly earnings as calculated under 405 IAC 2-5-1 that are equal to or greater than the federal minimum wage times forty (40), unless the provisions in *[subsection]* (c) are met.

(c) A recipient who is involuntarily not working can remain eligible for the Medicaid for employees with disabilities program for up to twelve (12) months if he or she meets all other program requirements and is either:

(1) on temporary medical leave from his or her employment as defined in *[subsection]* (d); or

(2) maintains a connection to the workforce by participating in at least one (1) of the following activities below:

(A) Enrollment in a vocational rehabilitation program.

(B) Enrollment or registration with the department of workforce development.

(C) Participation in a transition from school to work program.

(D) Participation with an approved provider of employment services.

(d) As used in this section, "temporary medical leave" means a leave from the place of employment due to health reasons when the employer is keeping a position open for the individual to return. If the employer is no longer holding a position open, the recipient must maintain a connection to the workforce as defined in subdivision *[subsection]* (c)(2) in order for coverage to continue under Medicaid for employees with disabilities.

(e) In order to remain eligible upon becoming unemployed, the recipient or his or her authorized representative must submit a written request for continued coverage to the local office of family and children no later than sixty (60) days after termination of employment. Attached to this written request must be verification that the recipient meets the requirements in subsection (c). On a quarterly basis thereafter, as long as the recipient continues to be unemployed and wishes coverage to continue, verification of his or her medical leave or workforce connection status must be provided to the local office of family and children. The quarterly verification must consist of a statement from the agency or service provider that documents the recipient's continued participation in an activity that constitutes connection to the workforce, or from the recipient's employer stating he or she remains on a temporary involuntary medical leave.

(f) A recipient who voluntarily terminates his or her employment for any reason is not eligible for Medicaid for employees with disabilities. Eligibility for the other Medicaid categories will be pursued.

(g) A recipient who fails to submit the initial request for coverage continuation within the required sixty (60) day period, or who fails to submit the quarterly verification report is no longer eligible for Medicaid for employees with disabilities. Eligibility

for other Medicaid categories will be pursued. *(Office of the Secretary of Family and Social Services; 405 IAC 2-9-5; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3119; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769)*

405 IAC 2-9-6 Medical disability determination

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15
Affected: IC 12-14-15-1; IC 12-15-2-6.5; IC 12-15-41

Sec. 6. (a) In order to qualify for Medicaid for employees with disabilities, an applicant must meet the definition of disability in IC 12-14-15-1(2). If not for earned income, the applicant or recipient would medically qualify for Medicaid under the traditional disability category according to statute.

(b) The determination of disability is made by the Medicaid medical review team (MMRT) based upon the principles found in 405 IAC 2-2-3, except that the determination of whether an impairment is substantial enough to meet the definition of disability is made without considering work activity, earnings, and substantial gainful activity (SGA). If not for the fact that the applicant or recipient is working, the condition would otherwise be substantial enough to prevent the person from participating in gainful activity.

(c) A redetermination of disability is required annually of each recipient at the time the county office does its complete redetermination of all factors of eligibility. A redetermination of disability may be required more frequently or may be waived at the discretion of the MMRT based upon the condition of the recipient. *(Office of the Secretary of Family and Social Services; 405 IAC 2-9-6; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120)*

405 IAC 2-9-7 Medically improved disability

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15
Affected: IC 12-14-15-1; IC 12-15-2-6.5; IC 12-15-41

Sec. 7. (a) In order to qualify for the Medicaid for employees with disabilities program after improvement of a medical condition, a recipient must meet the requirements in this section.

(b) The person must be a recipient of Medicaid under the Medicaid for employees with disabilities group described in section 6 of this rule who no longer qualifies for coverage under that category due to a medical improvement in his or her condition. The improvement of the condition must be verifiable by acceptable clinical standards; however, the disease, illness, or process must be of a type that, due to the nature and course of the illness, will continue to be a disabling impairment. A condition that has been resolved or a person who is completely recovered does not medically qualify for this program.

(c) The determination of whether a recipient meets the medical eligibility requirements for this category will be made at the time of the regularly scheduled annual redetermination for Medicaid by the county office. Determination of medical eligibility under this section is made by the Medicaid medical review team (MMRT). *(Office of the Secretary of Family and Social Services; 405 IAC 2-9-7; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120)*

405 IAC 2-9-8 Premiums

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15
Affected: IC 12-14-15-1; IC 12-15-2-6.5; IC 12-15-41

Sec. 8. (a) To be eligible for Medicaid for employees with disabilities, an individual must pay monthly premiums in accordance with the requirements specified in this section, unless the gross income of the individual and the individual's spouse is less than one hundred fifty percent (150%) of the federal poverty level. The amount of the premium is based on the gross income of the recipient and the recipient's spouse as a percentage of the federal poverty level for the applicable family size as determined in subsection (b) or (c). The amount of the premium will be adjusted by the premium amount of other creditable private health insurance as defined in 42 U.S.C. §300gg-91 that covers the applicant or recipient and is paid by the applicant or recipient or his or her spouse or parent. The amount of the premium is calculated as described in the following Table:

Income as a Percent of the Federal Poverty Level	Amount of Premium	
		Married
Less than 150% – No Premium is Required	Individual	Couple

150% to 175%	$ 48	$ 65
More than 175% to 200%	$ 69	$ 93
More than 200% to 250%	$ 107	$ 145
More than 250% to 300%	$ 134	$ 182
More than 300% to 350%	$ 161	$ 218
More than 350%	$ 187	$ 254

(b) The individual premium amount is used when the individual, regardless of age, is not married or not living with his or her spouse. When the individual premium amount is used, only the individual's income is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of one (1).

(c) The married couple premium amount is used when the individual is legally married and living with his or her spouse. When the couple premium amount is used, the income of both spouses is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of two (2).

(d) When an applicant is determined eligible, the applicant will be conditionally approved pending payment of the premium. The first month for which a premium is required is the month following the month in which an applicant is approved as conditional. After the premium is received, coverage will be retroactive to the first day of the third month prior to the month of application if all eligibility requirements were met in the prior months.

(e) The individual must pay the first premium in order to receive coverage. If payment is not received by the due date specified in the second premium notice, the Medicaid application will be denied. A payment of less than the full amount due will be considered nonpayment.

(f) If any premium after the first premium is not paid by the due date, coverage will continue for a maximum of sixty (60) days before being discontinued. When an individual or couple have been discontinued from the program due to nonpayment of premiums, an application must be filed in order to be considered for eligibility. To be reenrolled based on an application filed after such a discontinuance, the individual must pay all past due premiums in addition to premiums owed for the current application. Past due premiums remain the obligation of the individual as a condition of eligibility for two (2) years after the date of discontinuance.

(g) When both spouses are recipients of Medicaid for employees with disabilities, the enrollment and continued eligibility of the couple is based on the payment of the married couple premium amount. Failure to pay the required premium amount in accordance with this section will result in the discontinuance of Medicaid coverage for both spouses.

(h) When a recipient reports a change in income or marital status as required by section 1(d) of this rule, and the change results in a lower premium, the new premium amount will be effective the first month following the date in which verification of the change is received.

(i) When a recipient who is eligible for Medicaid in the blind or disabled categories obtains employment, the change must be reported within ten (10) days as required by 470 IAC 2.1-1-2. An additional ten (10) days is allowed to provide verification of the employment. If the recipient is eligible for Medicaid for employees with disabilities, eligibility begins the first month following the date on which verification is received, subject to the timely notice requirements in 42 CFR 431.211. *(Office of the Secretary of Family and Social Services; 405 IAC 2-9-8; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769)*

ARTICLE 3. LOCAL STEP AHEAD COUNCILS

Rule 1. Definitions

405 IAC 3-1-1 Applicability

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 1. The definitions in this rule apply throughout this article. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-1; filed Aug 24, 1995, 9:00 a.m.: 19 IR 34; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-1-2 "Annual plan of action" defined
Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 2. "Annual plan of action" refers to the local step ahead council's plans, priorities, and recommendations for a specific year. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-2; filed Aug 24, 1995, 9:00 a.m.: 19 IR 34; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-1-3 "Coordinator" defined
Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 3. "Coordinator" refers to an individual who is chosen by the local step ahead council who assists in the planning, development, and other functions identified by the local step ahead council. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-3; filed Aug 24, 1995, 9:00 a.m.: 19 IR 34; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-1-4 "Fiscal agent" defined
Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 4. "Fiscal agent" refers to a local step ahead council or an incorporated entity identified by the local step ahead council who can receive and disburse funds. A fiscal agent may contract with public and private entities on behalf of a local step ahead council. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-4; filed Aug 24, 1995, 9:00 a.m.: 19 IR 34; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-1-5 "Local step ahead council" defined
Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 5. "Local step ahead council" means the local entity approved by the step ahead panel in each county. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-5; filed Aug 24, 1995, 9:00 a.m.: 19 IR 34; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-1-6 "Panel" defined
Authority: IC 12-8-1-9
Affected: IC 20-1-1.8-13

Sec. 6. "Panel" refers to the state step ahead panel established to implement step ahead under IC 20-1-1.8-13. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-6; filed Aug 24, 1995, 9:00 a.m.: 19 IR 35; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-1-7 "Step ahead coordination grant" defined
Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 7. "Step ahead coordination grant" refers to funds provided to a local step ahead council or to a fiscal agent identified by the local step ahead council to support the local council's collaborative planning and development process. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-7; filed Aug 24, 1995, 9:00 a.m.: 19 IR 35; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-1-8 "Step ahead discretionary grant" defined

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 8. "Step ahead discretionary grant" refers to funds provided to a local step ahead council or to a fiscal agent identified by the local step ahead council to assist in the implementation of the local step ahead council's annual plan of action. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-8; filed Aug 24, 1995, 9:00 a.m.: 19 IR 35; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-1-9 "Strategic plan" defined

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 9. "Strategic plan" refers to plans developed by a local step ahead council setting forth comprehensive goals and objectives of the local step ahead council. *(Office of the Secretary of Family and Social Services; 405 IAC 3-1-9; filed Aug 24, 1995, 9:00 a.m.: 19 IR 35; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 2. General Provisions

405 IAC 3-2-1 Panel as the governing body

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 1. (a) The panel is the governing body for each local step ahead council.

(b) The panel consists of sixteen (16) members of which twelve (12) are appointed by the governor and four (4) are appointed by the superintendent of public instruction.

(c) The panel shall approve the step ahead grants developed by the local step ahead councils.

(d) The panel shall review the annual plan of action developed by the local step ahead councils.

(e) The panel shall recommend the types of community representatives that may be given an opportunity to be a member of a local step ahead council.

(f) The panel may withdraw recognition of a local step ahead council for reasons including, but not limited to, the following:

(1) Failure to comply with approved policies and guidelines approved by the panel.

(2) Inappropriate use of available funds.

(g) Notice of a withdrawal action shall be given in writing to the local step ahead council.

(h) A local step ahead council may appeal the decision of the panel to withdraw recognition and shall be given an opportunity to be heard. *(Office of the Secretary of Family and Social Services; 405 IAC 3-2-1; filed Aug 24, 1995, 9:00 a.m.: 19 IR 35; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-2-2 Local step ahead councils

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 2. (a) There may be established in each county a local step ahead council.

(b) Only one (1) organization will be recognized by the panel as the local step ahead council in that county. *(Office of the Secretary of Family and Social Services; 405 IAC 3-2-2; filed Aug 24, 1995, 9:00 a.m.: 19 IR 35; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-2-3 Powers and duties of the local step ahead councils

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 3. (a) The local step ahead council is responsible for the planning, development, implementation, design, and evaluation of a comprehensive local system of service delivery for children and families.

(b) The local step ahead council may identify available local, state, and federal funds in addition to the funds appropriated by the general assembly to assist in the implementation of the service delivery for children and families.

(c) The local step ahead council may make arrangements to use available funds to enhance and expand direct services for children and families.

(d) A local step ahead council, or an incorporated entity identified by the local step ahead council to receive and disburse funds, may act as fiscal agent and may do the following:

(1) Apply for grants.

(2) Enter into contracts.

(Office of the Secretary of Family and Social Services; 405 IAC 3-2-3; filed Aug 24, 1995, 9:00 a.m.: 19 IR 35; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 3-2-4 Roles and responsibilities

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 4. (a) The roles and responsibilities of a local step ahead council include, but are not limited to, the following:

(1) Identifying the needs of the county as they relate to children and families.

(2) Identifying present and prospective resources and services available to children and families.

(3) Acting as a liaison between public and private organizations, providers, the community, and local, state, and federal governments, including mobilizing family, private, and public resources for services.

(4) Facilitating coordination efforts among agencies serving the needs of children and families, including addressing accessibility needs.

(5) Facilitating local service delivery programs, including coordinating referral procedures for children and families.

(6) Streamlining funding mechanisms.

(7) Exchanging information with other councils, the community, and agencies serving the needs of children and families.

(8) Developing and implementing a strategic plan.

(9) Developing and implementing an annual plan of action.

(10) Developing a data collection system regarding services and populations.

(11) Encouraging public participation.

(b) A local step ahead council may expand its comprehensive system to include all children, families, and individuals. *(Office of the Secretary of Family and Social Services; 405 IAC 3-2-4; filed Aug 24, 1995, 9:00 a.m.: 19 IR 36; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-2-5 Membership of local step ahead councils

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 5. (a) The local council shall provide an opportunity for voluntary membership to representatives of the following:

(1) Human services providers in the community.

(2) Parents and consumers of services.

(3) Public schools, private schools, and parochial schools, particularly those schools that provide preschool or special education preschool services.

(4) Child care early childhood.

(5) Head Start programs.

(6) County health departments.

(7) Community mental retardation and mental health centers that provide services to preschool children with disabilities.

(8) Vocational rehabilitation and vocational education.

(9) Infants and toddlers with disabilities programs.

(10) Woman, infants, and children (WIC) programs.

(11) The county office of family and children.
(12) Groups with expertise in child welfare.
(13) Employment and training.
(14) Business community.
(15) General purpose local government.
(16) Private health providers.
(17) Private industry council programs.
(18) Service organizations.
(19) Foundations.
(20) Legislators.
(21) Universities.
(22) Religious organizations.
(23) Juvenile justice.
(24) Area agency on aging.

(b) A local step ahead council or its board of directors shall elect by majority vote a coordinator and a fiscal agent. The coordinator and fiscal agent may not be the same person.

(c) The frequency of meetings and terms of membership shall be determined by each local step ahead council.

(d) Consistent with policies and guidelines issued by the panel, a local step ahead council shall adopt policies.

(e) A local step ahead council may elect a board of directors. *(Office of the Secretary of Family and Social Services; 405 IAC 3-2-5; filed Aug 24, 1995, 9:00 a.m.: 19 IR 36; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-2-6 Open door

Authority: IC 12-8-1-9
Affected: IC 5-14; IC 20-1-1.8

Sec. 6. A local step ahead council and its board of directors established under this rule are subject to IC 5-14 (the open door law). *(Office of the Secretary of Family and Social Services; 405 IAC 3-2-6; filed Aug 24, 1995, 9:00 a.m.: 19 IR 36; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-2-7 Audit

Authority: IC 12-8-1-9
Affected: IC 12-8-10; IC 20-1-1.8

Sec. 7. A local step ahead council which serves as the fiscal agent may be subject to an audit by the financial services group under IC 12-8-10. *(Office of the Secretary of Family and Social Services; 405 IAC 3-2-7; filed Aug 24, 1995, 9:00 a.m.: 19 IR 36; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 3-2-8 Existing local step ahead councils

Authority: IC 12-8-1-9
Affected: IC 20-1-1.8

Sec. 8. A local step ahead council in existence as of the effective date of this rule shall comply with this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 3-2-8; filed Aug 24, 1995, 9:00 a.m.: 19 IR 37; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

ARTICLE 4. PURCHASE OF PRODUCTS AND SERVICES OF PERSONS WITH DISABILITIES

Rule 1. Qualified Nonprofit Agencies

405 IAC 4-1-1 Criteria for qualified nonprofit agencies

Authority: IC 16-32-2-8
Affected: IC 16-32-2-8

Sec. 1. In order to be a qualified nonprofit agency for purposes of IC 16-32-2-8 *[IC 16-32-2-8 was repealed by P.L.49-1997, SECTION 86, effective July 1, 1998.]*, the nonprofit agency shall be accredited by CARF. *(Office of the Secretary of Family and Social Services; 405 IAC 4-1-1; filed Aug 7, 1996, 5:00 p.m.: 19 IR 3382)*

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 12-7-2-149; 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)

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)*

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)*

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)*

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) Health Care Financing Administration'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 shall be used by providers when submitting dental claims to the contractor for adjudication.

(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)*

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)*

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)*

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)*

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)*

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)*

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)*

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)*

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)*

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)*

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)

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)*

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)*

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)*

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)*

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)*

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)*

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)*

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)*

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)*

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)

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)*

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)*

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)*

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 12-7-2-149; 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)*

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)*

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)*

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)*

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)*

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)*

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)

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)*

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)*

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)

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)

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)*

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)*

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)

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)*

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)

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)

405 IAC 5-3-13 Services requiring 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. 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) Plasmapheresis.
(10) Strabismus surgery for patients over ten (10) years of age.
(11) Home health services.
(12) Maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures.
(13) Temporomandibular joint surgery.
(14) Submucous resection of nasal septum and septoplasty when associated with significant obstruction.
(15) Hysterectomy.
(16) Tonsillectomy.
(17) Tonsillectomy and adenoidectomy.
(18) Cataract extraction.
(19) Surgical procedures involving the foot.
(20) Weight reduction surgery, including gastroplasty and related gastrointestinal surgery.
(21) Any procedure ordinarily rendered on an outpatient basis, when rendered on an inpatient basis.
(22) All dental admissions.
(23) Stress electrocardiograms except for medical conditions.
(24) Brand medically necessary drugs.
(25) Other drugs as specified in accordance with 405 IAC 5-24-8.5.
(26) Psychiatric inpatient admissions, including admissions for substance abuse.
(27) Rehabilitation inpatient admissions.
(28) 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)*

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)*

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)*

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)

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)

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.

(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)

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)

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)

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)*

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)*

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)*

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)*

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)

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)*

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)*

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)*

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)*

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 four (4) per month or twenty (20) per year 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)*

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)*

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)*

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)

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)*

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)*

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)*

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)

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)*

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)*

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)*

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)

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)*

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)*

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)*

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)*

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 services associated with such visits, subject to the following restrictions:

(1) Reimbursement is limited to five (5) visits per recipient per year.

(2) Reimbursement is not available for the following types of extended or comprehensive office visits:

(A) New patient comprehensive.

(B) Established patient detailed.

(C) 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.

(4) A total of fifty (50) therapeutic physical medicine treatments, as defined by applicable procedure code, are reimbursable per recipient, per year.

(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)

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 16-39-1-2; 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. Under IC 16-39-1-2, chiropractors are entitled to receive x-rays from other providers at the other providers' actual cost upon a patient'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)

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)*

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)*

405 IAC 5-12-6 Electromyography 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. 6. Electromyography procedures are reimbursable only if prior authorization has been obtained. *(Office of the Secretary of Family and Social Services; 405 IAC 5-12-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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 available for durable medical equipment (DME), subject to the following restrictions:
(1) DME items for which no reimbursement is allowed are those items specified by 405 IAC 5-19-1(b)(2).
(2) All items of DME provided by a chiropractor on a rental basis and having a first month rental charge of fifty dollars ($50) or greater require prior authorization in order to be reimbursable.
(3) All items of DME provided by a chiropractic provider on a rental basis require prior authorization for rental periods subsequent to the first month, irrespective of the rental charge.
(4) Items of DME provided by a chiropractic provider on a purchase basis and having a total charge of fifty dollars ($50) or greater require prior authorization in order to be reimbursable.
(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)

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)*

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)*

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)

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)

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)

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)*

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)

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)*

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)*

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

Sec. 1. 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. The dental portion of the Indiana Medicaid program places top priority on prevention, relief of pain, elimination of infection, and pathology. *(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)*

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.
(5) Sealant.
(6) Amalgam.
(7) Unilateral and bilateral space maintainers.
(8) Resin anteriors and posteriors.
(9) Recement crowns.
(10) Steel crown primary.
(11) Stainless steel crown permanent.
(12) Pin retention.

(13) Pulpcap.
(14) Therapeutic pulpotomy.
(15) Extractions.
(16) Oral biopsies.
(17) Alveoplasty.
(18) Excision of lesions.
(19) Excision of benign tumor greater than one and twenty-five hundredths (1.25) centimeters.
(20) Odontogenic cyst removal.
(21) Nonodontogenic cyst removal.
(22) Incise and drain abscess.
(23) Sequestrectomy osteomyelitis.
(24) Fracture simple stabilize.
(25) Compound fracture of the mandible.
(26) Compound fracture of the maxilla.
(27) Repair of wounds.
(28) Suturing.
(29) Osteoplasty–for orthognathic deformity.
(30) Emergency treatment dental pain.
(31) Analgesia.
(32) Therapeutic drug injection.
(33) Drugs and medicaments.
(34) Treatment of complications postsurgery.
(35) Periodontal surgery limited to drug-induced periodontal hyperplasia.
(36) Other dental services as medically necessary to treat recipients eligible for the EPSDT program.
(37) Confirmatory consultations.
(38) Periodontal root planing and scaling.
(39) General anesthesia.
(40) Intravenous (IV) sedation.

(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)

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 full mouth series radiographs or panorex is limited to one (1) set per recipient every three (3) years.
(2) Bitewing, intra-oral, and extra-oral radiographs are limited to one (1) set per recipient every twelve (12) months. One (1) set is defined as a total of four (4) single films.
(3) A comprehensive or detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider.
(4) A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient, any provider.
(5) Mouth gum cultures and sensitivity tests are not covered.
(6) Oral hygiene instructions are reimbursed in the Medicaid payment allowance for diagnostic services and may not be billed separately to Medicaid.
(7) Payment for the writing of prescriptions is included in the reimbursement for diagnostic services and 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)

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 eighteen (18) months of age or older but who are younger than nineteen (19) years of age. Topical applications of fluoride are not covered for recipients nineteen (19) 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)*

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)*

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 over eighteen (18) 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 two (2) units every six (6) months.

(4) Prophylaxis is not covered for recipients under eighteen (18) 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)

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)*

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)*

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)

405 IAC 5-14-10 Pulpcap

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. Medicaid reimbursement is available for only one (1) pulpcap or one (1) base fill per tooth per recipient. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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 and preanesthetic medication are covered services. *(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)*

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)*

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)*

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)*

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. Prior authorization is required and shall include consideration of the following:

(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 when prior authorized. Prior authorization requests must include specific reasons why such services are needed, including specific justification 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)*

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. This service requires prior authorization. Requests for surgical periodontics will be evaluated and decided on an individual basis. *(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)*

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 approved, other than those listed in this rule, except in extreme cases of facial trauma, pathology, or deformity. All oral surgery in the categories described in this rule require prior authorization by the office. 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)*

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. 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, requires prior authorization by the office. Authorization will be given only for those recipients with problems that require special or additional care to that care routinely provided in a dentist's office. In cases of life-threatening emergencies, retroactive prior authorization must be obtained within forty-eight (48) hours of the hospital admission. *(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)*

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)*

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)

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)*

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)

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)*

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)

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)*

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)*

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)*

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)*

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	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)

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)*

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)*

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)

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)*

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)

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)*

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)

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)

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)*

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)*

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)

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)

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)*

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)*

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)*

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)

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

Sec. 1. (a) Medicaid reimbursement is available for medical supplies subject to the restrictions listed in this section.

(b) Incontinency supplies, including underpads, incontinent briefs and liners, diapers, and disposable diapers, are covered subject to prior authorization and the following limitations:

(1) The supplies in this subsection are covered only in cases of documented necessity, at a rate determined by the contractor.

(2) The supplies in this subsection are covered only for recipients three (3) years of age or older.

(c) All medical supplies must be ordered in writing by a physician.

(d) Medical and nonmedical supplies used in the usual care and treatment of a recipient in a long term care facility are included in the approved per diem rate for the facility and may not be billed separately by the facility or through a pharmacy or other provider. *(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)*

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)

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)*

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)*

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)*

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)*

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)

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)

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)*

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.

(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)

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)

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)*

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)

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)

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)

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)*

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)*

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)

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, outpatient mental health facilities, and psychologists endorsed as health service providers in psychology subject to the limitations set out in 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)*

405 IAC 5-20-2 Reserving beds in 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. 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 one (1) of the following conditions is 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 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 one (1) of the following conditions is 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) 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 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.

(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)

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)

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 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 a 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 a 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)

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)

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)

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 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)

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)

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.

(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. *(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)*

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)

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)

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)

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)

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)*

405 IAC 5-21-7 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. 7. Community mental health rehabilitation services, as defined in section 1(b) of this rule, are not subject to prior authorization. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

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)

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)*

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)*

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)*

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)*

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)

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)

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 therapist assistant under the direct on-site supervision of a licensed physical therapist for reimbursement. Only the activities in this subdivision related to the therapy can be performed by someone other than a licensed therapist or certified therapist assistant who must be under the direct on-site 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 patients, records, equipment, and supplies in accordance with established policies and procedures.

(G) Performing established clerical procedures.

(2) 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.

(3) 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.

(4) 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)

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)

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)

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)

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)*

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)

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)*

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)

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)*

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)*

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)*

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)

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)

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 maximum allowable cost (MAC) of the drug as determined by the Health Care Financing Administration under 42 CFR 447.332 as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(3) 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.

(4) 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, the Indiana Medicaid EAC is one (1) of the following:

(1) for brand name drugs, eighty-six and one-half percent (86.5%);

(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 reflect prevailing market conditions and ensure reasonable access by providers to drugs at or below the applicable state MAC rate.

(e) Pharmacies and providers that are enrolled in the Indiana Health Coverage Programs (IHCP) are required, as a condition of participation, to make available and submit to the OMPP or its designee acquisition cost information, product availability information, or other information deemed necessary by the OMPP for the efficient operation of the pharmacy benefit within the IHCP in the format requested by the OMPP or its designee. Providers will not be reimbursed for this information and will submit information to the OMPP or its designee within thirty (30) days following a request for such information unless the OMPP 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)*

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 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.

(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)

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)*

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 as follows:

(A) Fifty cents ($0.50) for each generic drug dispensed, irrespective of the Medicaid payment for the generic drug.

(B) Fifty cents ($0.50) for each brand name drug dispensed for which the Medicaid payment is ten dollars ($10) or less.

(C) One dollar ($1) for each brand name drug dispensed for which the Medicaid payment is from ten dollars and one cent ($10.01) to thirty dollars ($30).

(D) Two dollars ($2) for each brand name drug dispensed for which the Medicaid payment is from thirty dollars and one cent ($30.01) to fifty-five dollars ($55).

(E) Three dollars ($3) for each brand name drug dispensed for which the Medicaid payment is fifty-five dollars and one cent ($55.01) or more.

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)

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)*

405 IAC 5-24-8.5 Prior authorization; other drugs

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-6; IC 12-15-35

Sec. 8.5. (a) Except as provided in section 8.6 of this rule, the office may, in compliance with all state and federal laws that may govern Medicaid prior authorization programs, establish prior authorization requirements for other drugs covered under Medicaid. Before any single source drug is placed on prior authorization in the fee for service program, the office will seek the advice of the drug utilization review board established under IC 12-15-35 at a public meeting held by the board. The single source drugs subsequently identified as subject to prior authorization under this section shall be published in a provider bulletin. Any provider bulletin described in this section shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(b) 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. 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 5-24-8.5; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1613)*

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

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-35

Sec. 8.6. (a) Central nervous system drugs classified by Drug Facts and Comparisons (published by Facts and Comparisons Division of J.B. Lippincott Company) as antianxiety, antidepressant, or antipsychotic agents, or any drugs cross-indicated (according to The American Psychiatric Press Textbook of Psychopharmacology, The Current Clinical Strategies for Psychiatry, Drug Facts and Comparison, or other publications of similar content and focus) to these classifications will not be placed on prior authorization in the fee for service Medicaid program. Drugs classified in any new category or classification of central nervous system agents (according to Drug Facts and Comparisons) created after the effective date of this rule, when prescribed for the treatment of mental illness (as defined in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association), will not be placed on prior authorization in the fee for service Medicaid program. As used in this subsection, "cross-indicated" means a drug that is being used for a purpose generally held to be reasonable, appropriate, and within community standards of practice, even though the use is not included in the FDA-approved labeled indications for the drug.

(b) Brand name multisource drugs described in subsection (a) shall not be subject to prior authorization under section 8 of this rule.

(c) A recipient enrolled in the fee for service Medicaid program shall have unrestricted access to the drugs described in this section except as provided in section 11 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-8.6; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1614; errata filed Feb 14, 2002, 11:30 a.m.: 25 IR 2255)*

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)*

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)*

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

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

Sec. 11. Nothing in this rule prohibits the office from placing limits on quantities dispensed or frequency of refills for any drug for purposes of preventing fraud, abuse, waste, overutilization, inappropriate utilization, or implementing disease management. In formulating any such limitations, the office will take into account quality of care and the best interests of Medicaid recipients. Before imposing any limits on quantities dispensed or frequency of refills for any drug, the office will seek the advice of the drug utilization review board established under IC 12-15-35 at a public meeting held by the board. Any limitations imposed shall be published in a provider bulletin. Any provider bulletin described in this subsection shall be made effective no earlier than permitted under IC 12-15-13-6(a). *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-11; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1614)*

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)*

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)*

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)*

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)

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)*

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)*

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)*

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)

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)*

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)

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 5-21.

(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)

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)*

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)

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)

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)

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)*

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)

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)

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)*

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)*

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)*

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)*

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)*

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)*

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)

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)

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)*

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)

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)*

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)

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)

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)

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)*

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)

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)

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)

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)

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)

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)

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)

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)

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)

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)*

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)*

Rule 31. Nursing Facility Services

405 IAC 5-31-1 Reimbursement

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; 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 when rendered to a Medicaid recipient whose level of care has been approved by the office. *(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)*

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)*

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 14.6 *[sic.]*. 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;

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.

(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)

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)*

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)*

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)*

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)*

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)

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)

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)

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)

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)

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. *(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)*

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

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 Health Care Financing Administration must be submitted with the Medicaid provider enrollment agreement.

(c) The provider must comply with all state and federal requirements for Medicaid providers in addition to the requirements in this section.

(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)

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 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) 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.

(c) Inpatient respite care and general inpatient care hospice services may be provided in an out-of-state hospice provider's facility.

(d) 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)*

405 IAC 5-34-4 Prior approval 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 prior approval by the office or its contractor. In order to obtain prior approval, the provider must submit all of the following as detailed in this rule:

(1) Recipient election statement.

(2) Physician certification.

(3) Plan of care.

(b) Hospice eligibility 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.

(c) Approval must be granted separately for each benefit period. 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 prior approval of the second and subsequent benefit periods.

(d) 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)*

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 that the individual is terminally ill and expected to die from that illness within six (6) months.

(b) The certification in subsection (a) must:

(1) be completed by:

(A) the medical director of the hospice program; or

(B) the physician member of the disciplinary group and the recipient's attending physician if the recipient has an attending physician;

(2) be signed and dated;

(3) identify the diagnosis that prompted the individual to elect hospice services;

(4) include a statement that the prognosis is six (6) months or less; and

(5) be submitted to the office or its designee within the timeframes in subsection (c).

(c) The physician certification must be submitted for the first period within ten (10) business days of the effective date of the recipient's election. For the second and subsequent periods, the physician certification must be submitted within ten (10) business days of the beginning of the benefit period. *(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)*

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) The election form must be submitted to the office or its designee along with the physician's certification required by section 5 of this rule when hospice services are initiated. It is not necessary to submit the election form for the second and subsequent benefit periods unless the recipient has revoked the election and wishes to reelect hospice care.

(e) 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.

(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.

(f) 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. *(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)*

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. The provider must submit the plan to the office or the office's contractor with the physician certification and the 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.

(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)

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)

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)*

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)*

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)

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)*

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; IC 12-17-15

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)

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; IC 12-17-15

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)

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; IC 12-17-15

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)

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; IC 12-17-15

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)*

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)*

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)*

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)

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)*

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)

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)

ARTICLE 6. INDIANA PRESCRIPTION DRUG PROGRAM

Rule 1. General Provisions

405 IAC 6-1-1 Intent and purpose

Authority: IC 12-10-16-5
Affected: IC 12-10-16-3

Sec. 1. Under IC 12-10-16-3, the office of the secretary of family and social services hereby adopts and promulgates this article to:

(1) interpret and implement the provisions of IC 12-10-16-3 to provide assistance with the expense of prescription drugs for low income seniors; and

(2) ensure the efficient, economical, and reasonable operations of the Indiana prescription drug program.

(Office of the Secretary of Family and Social Services; 405 IAC 6-1-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)

405 IAC 6-1-2 Annual report

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. On an annual basis, the office shall provide a report describing the program's activities, and such other information pertaining to the program as may be requested, to the state budget agency. *(Office of the Secretary of Family and Social Services; 405 IAC 6-1-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

Rule 2. Definitions

405 IAC 6-2-1 Applicability
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. The definitions in this rule apply throughout this article unless the context clearly indicates another meaning. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

405 IAC 6-2-2 "Applicant" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. "Applicant" means the person for whom Indiana prescription drug program enrollment is requested. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

405 IAC 6-2-3 "Benefit period" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. "Benefit period" means a specified time frame during which an enrollee accrues the cost of prescription drugs. The benefit periods are specified in 405 IAC 6-5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

405 IAC 6-2-4 "Child" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. "Child" means any child for whom the applicant or spouse has legal guardianship or legal custody, and who is either less than eighteen (18) years of age, or between eighteen (18) and twenty-one (21) years of age and a student. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

405 IAC 6-2-5 "Complete application" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. "Complete application" means an application which includes the following information about the applicant and applicant's spouse, if applicable:

(1) Name.
(2) Address.
(3) Date of birth.
(4) Whether the person had health insurance in the past six (6) months.
(5) Whether the person currently has insurance that includes a prescription drug benefit.
(6) Whether the person is on Medicaid.
(7) Whether the person has lived in Indiana for at least ninety (90) days in the past twelve (12) months.
(8) Proof of income. and
(9) Signature.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-5; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)

405 IAC 6-2-6 "Earned income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 6. "Earned income" means income the applicant earns through employment. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-6; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-7 "Eligible" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 7. "Eligible" means a person who meets all requirements for enrollment in the program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-7; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-8 "Enrollee" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 8. "Enrollee" means an applicant who has met all requirements and has been enrolled into the program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-8; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-9 "Family" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 9. "Family" means the applicant, spouse, and any child who live in the same residence. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-9; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-10 "Family member standard" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 10. "Family member standard" means the difference between the net monthly income limit for a family of two (2) and a family of three (3). *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-10; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-11 "Federal poverty guideline" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 11. "Federal poverty guideline" means the nonfarm income official poverty guideline as determined annually by the federal Office of Management and Budget. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-11; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-12 "Health insurance with a prescription drug benefit" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 12. "Health insurance with a prescription drug benefit" means any contract with an insurance company or organization approved or recognized by the Indiana department of insurance under which an individual receives health benefits, including a prescription drug benefit. This term includes Medicaid and veteran's benefits. A prescription discount card offered by an insurance company or organization is not considered to be a prescription drug benefit. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-12; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-13 "Indiana prescription drug program" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 13. "Indiana prescription drug program" means the program established by IC 12-10-16. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-13; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-14 "Net income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 14. "Net income" means the earned and unearned income that an applicant and an applicant's family receives, calculated on a monthly basis. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-14; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-15 "Not eligible" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 15. "Not eligible" means a person who does not meet one (1) or more of the requirements for enrollment in the program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-15; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-16 "Office" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 16. "Office" means the office of the secretary of family and social services. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-16; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-17 "Prescription drug" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 17. "Prescription drug" means any legend drug covered under the Medicaid fee-for-service program, as defined in 405 IAC 5-24-3, and insulin. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-17; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-18 "Prescription printout" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 18. "Prescription printout" means an itemized report prepared by a pharmacy for an enrollee showing prescription data for the enrollee for a stated benefit period. Such prescription data must include, but is not limited to:
(1) enrollee name and address;
(2) prescription number;
(3) NDC Code;
(4) drug name;
(5) drug strength;
(6) dosage form;
(7) quantity dispensed;
(8) date of dispense; and

(9) the amount paid by the enrollee or any insurance plan.
(Office of the Secretary of Family and Social Services; 405 IAC 6-2-18; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)

405 IAC 6-2-19 "Program" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 19. "Program" means the Indiana prescription drug program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-19; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-20 "Proof of income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 20. "Proof of income" means documentation of the earned and unearned income of an applicant and an applicant's family. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-20; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-21 "Refund certificate" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 21. "Refund certificate" means the document issued to an enrollee by the office which authorizes the enrollee to request a refund for prescription drugs purchased during a benefit period. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-21; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

405 IAC 6-2-22 "Refund period" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 22. "Refund period" means the period of time during which an enrollee can submit a refund certificate and prescription printout in order to request a refund for prescription drugs purchased during a corresponding benefit period. The refund periods are specified in 405 IAC 6-6-3. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-22; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

405 IAC 6-2-23 "Secretary" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 23. "Secretary" means the secretary of family and social services. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-23; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

405 IAC 6-2-24 "Senior" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 24. "Senior" means a person sixty-five (65) years of age or older. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-24; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

405 IAC 6-2-25 "Spouse" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 25. "Spouse" means the legal husband or wife of an applicant. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-25; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

405 IAC 6-2-26 "Unearned income" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 26. "Unearned income" means income the applicant receives from a source other than employment including, but not limited to, Social Security, Supplemental Security Income, pensions, or income from assets. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-26; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

Rule 3. Application and Enrollment; General Requirements

405 IAC 6-3-1 Application process

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) An application for the program shall be filed on the form prescribed by the office and shall include proof of income.
(b) An application shall be made in a manner prescribed by the office and can be made at any time.
(c) An application for the program may be filed on behalf of an applicant by any of the following:
(1) The applicant.
(2) The applicant's spouse.
(3) A court-appointed guardian of the applicant. or
(4) By power of attorney.
(d) The applicant may use an authorized representative to apply for the program. The authorization must be in writing and signed by a person authorized to file an application under subsection (c). *(Office of the Secretary of Family and Social Services; 405 IAC 6-3-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

405 IAC 6-3-2 Date of application

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. For purposes of determining the effective date of availability of the program to an applicant, the date of application is the date the application is received by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 6-3-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

405 IAC 6-3-3 Date of availability

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. The program is available to an applicant beginning with the benefit period prior to the one in which the applicant applies for enrollment in the program. The program is not available for prescription drugs purchased prior to the month in which the applicant turned sixty-five (65) years of age. *(Office of the Secretary of Family and Social Services; 405 IAC 6-3-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

Rule 4. Eligibility Requirements

405 IAC 6-4-1 Age

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. To be eligible for the program, an applicant must be sixty-five (65) years of age or older. *(Office of the Secretary of Family and Social Services; 405 IAC 6-4-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

405 IAC 6-4-2 Income

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) To be eligible for the program, an applicant's monthly family net income must not exceed the income limit listed below for the applicant's family size:

Family Size	Net Monthly Income Limit
1	$940
2	$1,266
3	$1,592

(b) For each additional family member over three (3), the family member standard shall be added to the net monthly income limit for a family of three (3) in order to calculate the net monthly income limit. A child who earns more than the family member standard per month is not included in the calculation of monthly net income or in family size.

(c) The monthly net income limits are determined by multiplying the federal poverty guideline for each family size by one hundred thirty-five percent (135%), dividing by twelve (12), and then rounding up to the next whole dollar.

(d) The income standards in *[subsection]* (a) shall increase annually in the same percentage (%) amount that is applied to the federal poverty guideline. The increase shall be effective on the first day of the second month following the month of publication of the federal poverty guideline in the Federal Register. *(Office of the Secretary of Family and Social Services; 405 IAC 6-4-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

405 IAC 6-4-3 Ineligibility

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. Notwithstanding any other provision of this article, an individual is not eligible for the program if any of the following apply:

(1) The individual had health insurance with a prescription drug benefit during the prior benefit period and, at the time of application, the individual has health insurance with a prescription drug benefit.

(2) The individual has not resided in Indiana for ninety (90) days or more during the past twelve (12) months.

(3) The individual is an inmate of a correctional facility.

(Office of the Secretary of Family and Social Services; 405 IAC 6-4-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)

Rule 5. Benefits

405 IAC 6-5-1 Prescription drug coverage

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. The program shall issue a partial refund to an enrollee for the purchase of prescription drugs, as defined under this article, based upon the limitations set forth in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

405 IAC 6-5-2 Benefit defined by family income level

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) The refund issued to an enrollee per benefit period is limited by family income as follows:

Income Guideline	Individual's Monthly Net Income	Couple's Monthly Net Income	Annual Benefit
Up to 135% of federal poverty guideline	Up to $940 per month	Up to $1,266 per month	50% refund, up to $500 benefit/year
Up to 120% of federal poverty guideline	Up to $835 per month	Up to $1,125 per month	50% refund, up to $750 benefit/year
Under 100% of federal poverty guideline	Up to $696 per month	Up to $938 per month	50% refund, up to $1,000 benefit/year

(b) An enrollee and spouse who are enrolled in the program will each receive the maximum refund of prescription drug expenses up to the annual benefit in subsection (a) for which they qualify by family income level.

(c) The benefit income guidelines are determined by multiplying the federal poverty guideline for each family size by each income guideline percentage (%), dividing by twelve (12), and then rounding up to the next whole dollar.

(d) The benefit income guidelines in *[subsection]* (a) shall increase annually in the same percentage (%) amount that is applied to the federal poverty guideline. The increase shall be effective on the first day of the second month following the month of publication of the federal poverty guideline in the Federal Register. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

405 IAC 6-5-3 Benefit period

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. The program shall consist of four benefit periods per year, defined as follows:

(1) Benefit period one: October 1 through December 31.
(2) Benefit period two: January 1 through March 31.
(3) Benefit period three: April 1 through June 30.
(4) Benefit period four: July 1 through September 30.

(Office of the Secretary of Family and Social Services; 405 IAC 6-5-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)

405 IAC 6-5-4 Benefit duration

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. The program is available to an enrollee for a maximum of four (4) consecutive benefit periods. To reenroll in the program following the expiration of the enrollee's last benefit period, a new application must be submitted to the office in accordance with this article. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

405 IAC 6-5-5 Benefit period ineligibility

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. (a) An enrollee is ineligible for a refund for prescription drugs purchased during any benefit period in which the enrollee has health insurance with a prescription drug benefit.

(b) Ineligibility for a refund under *[subsection]* (a) does not terminate enrollment in the program. An enrollee may request a refund during any later benefit period during which the enrollee does not have health insurance with a prescription drug benefit. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-5; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

405 IAC 6-5-6 Benefits; program appropriations

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 6. (a) Upon submission of a completed refund certificate, benefits are available under this program on a first come, first serve basis.

(b) Benefits will exist under this program to the extent that appropriations are available for the program.

(c) The state budget director shall determine if appropriations are available to continue paying benefits to enrollees. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-6; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

Rule 6. Program Procedure

405 IAC 6-6-1 Application process

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) A complete application will be processed by the office.

(b) An applicant who submits an incomplete application will be deemed ineligible for the program. Such an applicant may reapply for the program at any time or may file for written review of the determination in accordance with this article. *(Office of the Secretary of Family and Social Services; 405 IAC 6-6-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)*

405 IAC 6-6-2 Letter of eligibility

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. Once the office has processed a complete application, the applicant will receive a letter of eligibility by mail notifying the applicant of his or her status in the program. An applicant will either be eligible and enrolled in the program, or ineligible and not enrolled in the program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-6-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)*

405 IAC 6-6-3 Refund certificates

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) An enrollee will receive up to four (4) refund certificates with a letter of eligibility which enrolls the applicant into the program.

(b) Each refund certificate corresponds to one (1) of four (4) refund periods as defined below:

(1) Refund period one: January 1 through March 31.
(2) Refund period two: April 1 through June 30.
(3) Refund period three: July 1 through September 30.
(4) Refund period four: October 1 through December 31.

(c) Each refund period corresponds to one (1) benefit period as set forth below:

Benefit Period	Refund Period
October 1 through December 31	January 1 through March 31
January 1 through March 31	April 1 through June 30
April 1 through June 30	July 1 through September 30
July 1 through September 30	October 1 through December 31

(Office of the Secretary of Family and Social Services; 405 IAC 6-6-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)

405 IAC 6-6-4 Refund certificate redemption

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) During each refund period, the enrollee must submit the applicable refund certificate with the prescription printout for the corresponding benefit period to the office in the manner prescribed by the office.

(b) The refund period deadline is the date which corresponds to the later of thirty-five (35) days from the date on the letter of eligibility or the last day of the applicable refund period.

(c) An enrollee will be notified by mail if the enrollee submits an incomplete request for refund. An incomplete request for refund includes:

(1) an unsigned refund certificate;

(2) a refund certificate with no insurance verification;

(3) a prescription printout which fails to state all information in 405 IAC 6-2-17;

(4) the absence of a refund certificate for the applicable benefit period;

(5) the absence of a prescription printout for the applicable benefit period; or

(6) the absence of any other information that is necessary under this article to process a refund request.

The enrollee must submit the information requested in the letter of notification by the deadline in the letter of notification.

(d) Refund certificates received by the office after the refund deadline date will not be processed and no refund will be issued. Any refund certificate or prescription printout requested in *[subsection]* (c) that is received by the office after the stated deadline date will not be processed and no refund will be issued. *(Office of the Secretary of Family and Social Services; 405 IAC 6-6-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)*

Rule 7. Administrative Review and Administrative Appeal Procedures for Applicants and Enrollees

405 IAC 6-7-1 Purpose

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) It is the purpose of this rule to establish a uniform method of administrative review and administrative adjudication for appeals concerning applicants and enrollees of the program, in order to determine whether or not any action for which there is a complaint was done in accordance with state statutes, regulations, rules, and policies. As used in this rule, "policies" includes program manuals, administrative directives, transmittals, and other official written pronouncements of state policy.

(b) This rule shall be construed in such a manner as to provide all parties with an adequate opportunity to be heard in accordance with due process of law. As used in this rule, "party" means:

(1) a person to whom the agency action is specifically directed; or

(2) the office of the secretary of family and social services.

(c) In the event that any provision of this article is deemed to be in conflict with any other provision of state statute, regulation, or rule that is specifically applicable to the program, then such other statute, regulation, or rule shall supersede that part of this article in which the conflict is found. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)*

405 IAC 6-7-2 Standing

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) In the event that the rights, duties, obligations, privileges, or other legal relations of any person or entity are required or authorized by law to be determined by the office, then such person or entity may request an administrative review by the office as provided for in section 3 of this rule.

(b) Unless otherwise provided by law, only those persons or entities, or their respective attorneys at law, whose rights, duties, obligations, privileges, or other legal relations are alleged to have been adversely affected by any action or determination of the office, may request administrative review under this rule. Any alleged harm to an enrollee or applicant must be direct and immediate

to the party and not indirect and general in character. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2462)*

405 IAC 6-7-3 Requests for administrative review

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) Any party complaining of an action of the office in accordance with this article may file a request for administrative review as provided in this section.

(b) The enrollee or applicant is required to seek administrative review prior to filing an administrative appeal under section 5 of this rule.

(c) Unless otherwise provided for by statute, regulation, or rule, a request for administrative review by an enrollee or applicant shall be filed in writing with the office not later than thirty-five (35) days following the date of the action being reviewed. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2462)*

405 IAC 6-7-4 Conduct of administrative review

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) Upon receipt of a request for administrative review, the office will conduct a review of the action.

(b) Upon completion of the review, the office will issue a written decision. The decision will be final unless a party requests an administrative appeal in accordance with this rule.

(c) The written decision shall specify the reasons for the decision and identify the statutes, regulations, rules, and policies supporting the decision. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2462)*

405 IAC 6-7-5 Filing an administrative appeal; scheduling appeals

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. (a) Any party who is not satisfied with the administrative review of the office as provided for in this rule may file a request for an administrative appeal as provided in this section. The person or entity requesting the administrative appeal shall be known as the appellant.

(b) Unless otherwise provided for by statute, regulation, or rule, appeal requests by appellant's *[sic., an appellant]* shall be filed in writing with the hearings and appeals section of the family and social services administration not later than thirty (30) days following the effective date of the administrative review being appealed. Appeal hearings shall be conducted at a reasonable time, place, and date.

(c) The hearings and appeals section of the family and social services administration, upon application of any party, or in its own discretion, may consolidate appeals to promote administrative efficiency. Hearings may only be consolidated in cases in which the sole issue involved is one of state law or policy.

(d) Any party filing an appeal under this rule is not excused from exhausting all interim procedures that may be required by statute or rule for administrative review prior to the filing of an administrative appeal. Any issues not raised within the interim review procedures of the administrative review in a timely manner are waived and shall not be an issue during the evidentiary hearing of the administrative appeal.

(e) The hearings and appeals section of the family and social services administration will schedule evidentiary hearings and issue notices to the parties regarding the date, time, and location of the scheduled hearing.

(f) A continuance of a hearing will be granted only for good cause shown. An objection to a request for a continuance shall be considered before a continuance is granted or denied. Requests for a continuance shall be in writing and accompanied by adequate documentation of the reasons for the request. Good cause includes:

(1) inability to attend the hearing because of a serious physical or mental condition;

(2) incapacitating injury;

(3) death in the family;
(4) severe weather conditions making it impossible to travel to the hearing;
(5) unavailability of a witness and the evidence cannot be obtained otherwise; or
(6) other reasons similar to those listed in this section.

If the appellant is represented by counsel, the request for continuance must also include alternative dates for the scheduling of a new hearing. However, the hearings and appeals section may schedule a new hearing without respect to the requested date if such date cannot be accommodated or confirmed with the requesting attorney within a reasonable time of the request. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-5; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2462)*

405 IAC 6-7-6 Conduct and authority of administrative law judge

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 6. (a) An administrative law judge's (ALJ) conduct shall be in a manner that promotes public confidence in the integrity and impartiality of the administrative hearing process. The ALJ who conducts a hearing is prohibited from:

(1) consulting any party or party's agent on any fact in issue unless upon notice and opportunity for all parties to participate;
(2) performing any of the investigative or prosecutorial functions of the family and social services administration in the administrative appeal heard or to be heard by him or her or in a factually related administrative or judicial action;
(3) being influenced by partisan interests, public clamor, or fear of criticism;
(4) conveying or permitting others to convey the impression that they are in a special position to influence the ALJ;
(5) commenting publicly, except as to hearing schedules or procedures, about pending or impending proceedings; or
(6) engaging in financial or business dealings that tend to:
    (A) reflect adversely on his or her impartiality;
    (B) interfere with the proper performance of his or her duties;
    (C) exploit the ALJ's position; or
    (D) involve the ALJ in frequent financial business dealings with attorneys or other persons who are likely to come before the ALJ.

(b) An ALJ shall disqualify himself or herself in a proceeding in which his or her impartiality might reasonably be questioned, or in which the ALJ's personal bias, prejudice, or knowledge of a disputed evidentiary fact might influence the decision. Nothing in this subsection prohibits a person who is an employee of the family and social services administration from serving as an ALJ.

(c) The ALJ shall be authorized to:
(1) administer oaths and affirmations;
(2) issue subpoenas;
(3) rule upon offers of proof;
(4) receive relevant evidence;
(5) facilitate discovery in accordance with the Indiana rules of trial procedure;
(6) regulate the course of the hearing and conduct of the parties;
(7) hold informal conferences for the settlement or simplification of the issues under appeal;
(8) dispose of procedural motions and similar matters; and
(9) exercise such other powers as may be given by the law relating to the particular program area under appeal.

(Office of the Secretary of Family and Social Services; 405 IAC 6-7-6; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2463)

405 IAC 6-7-7 Conduct of hearing; hearing decisions

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 7. (a) The administrative law judge (ALJ) shall conduct the hearing in an informal manner and without recourse to the technical common law rules of evidence.

(b) The ALJ shall exclude from consideration irrelevant, immaterial, or unduly repetitious evidence.

(c) Every party shall have the right to submit evidence. In the event that an objection to evidence is sustained, the party proffering the evidence may make an offer of proof. Each party shall have the right to cross-examine the witnesses and offer

rebutting evidence. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-7; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2463)*

405 IAC 6-7-8 Hearing decision

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 8. (a) Following completion of the hearing, or after submission of briefs by the parties (if briefing is permitted by the ALJ), the ALJ shall issue his or her decision in the matter concurrently to the parties. The decision shall be final unless a party requests agency review of the decision in accordance with this rule.

(b) The ALJ's decision shall:

(1) include findings of fact;

(2) specify the reasons for the decision; and

(3) identify the evidence and statutes, regulations, rules and policies supporting the decision.

(c) The findings of fact need not include a recitation of every piece of evidence admitted in the evidentiary hearing. Rather, the findings should contain the basic facts that have formed the basis for the ALJ's ultimate decision. The ALJ's decision must also cite the relevant laws upon which the ultimate decision is based, and relate the facts to the law. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-8; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2463)*

405 IAC 6-7-9 Agency review

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 9. (a) Any party who is not satisfied with the decision of the administrative law judge (ALJ) may request agency review of the decision within ten (10) days of receipt thereof in accordance with instructions issued with the decision.

(b) After receiving a request for agency review of a hearing decision, the hearings and appeals section of the family and social services administration shall notify the parties when the decision will be reviewed. The agency review shall be completed by the secretary of the family and social services administration or the secretary's designee. All such reviews shall be conducted upon the record, as defined in section 7 of this rule, except that a transcript of the oral testimony shall not be necessary for review unless the party requests that one be transcribed at the party's expense.

(c) No new evidence will be considered during the agency review; however, any party wishing to submit a memorandum of law, citing evidence in the record, may do so pursuant to instructions issued by the hearings and appeals section of the family and social services administration.

(d) The secretary of family and social services administration or the secretary's designee shall review the ALJ's decision to determine if the decision is supported by the evidence in the record and is in accordance with statutes, regulations, rules and policies applicable to the issues under appeal.

(e) Following the review of the secretary or designee, the secretary or designee shall issue a written decision:

(1) affirming the decision of the ALJ;

(2) amending or modifying the decision of the ALJ;

(3) reversing the decision of the ALJ;

(4) remanding the matter to the ALJ for further specified action; or

(5) make *[sic., making]* such other order or determination as is proper on the record.

(f) The parties will be issued a written notice of the action taken as a result of the agency review. If the decision of the ALJ is reversed, amended, or modified, the secretary or designee shall state the reasons for the action in the written decision.

(g) The hearings and appeals section of the family and social services administration shall distribute the written notice on agency review to:

(1) all parties of record;

(2) the ALJ who rendered the decision following the evidentiary hearing; and

(3) any other person designated by the secretary or designee.

(Office of the Secretary of Family and Social Services; 405 IAC 6-7-9; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2464)

405 IAC 6-7-10 Agency record; judicial review

Authority: IC 12-10-16-5
Affected: IC 4-21.5-3-33; IC 4-21.5-5; IC 12-10-16

Sec. 10. (a) The record of the administrative proceedings shall be that as defined in IC 4-21.5-3-33.

(b) If the appellant is not satisfied with the secretary's final action after agency review, he or she may file for judicial review in accordance with IC 4-21.5-5.

(c) The appellant is required to seek agency review prior to filing a petition for judicial review. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-10; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2464)*

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