

**Document: Final Rule, Register Page Number: 25 IR 378**  
**Source:** November 1, 2001, Indiana Register, Volume 25, Number 2  
**Disclaimer:** This document was created from the files used to produce the official (printed) Indiana Register.  
However, this document is unofficial.

**TITLE 405 OFFICE OF THE SECRETARY OF  
FAMILY AND SOCIAL SERVICES**

LSA Document #01-58(F)

DIGEST

Amends 405 IAC 5-2-17 to clarify the definition of medical necessity. Amends 405 IAC 5-7-1 to clarify policy regarding suspension of incomplete prior authorization requests. Amends 405 IAC 5-8-3 to clarify consultations policy. Amends 405 IAC 5-19 to revise policy and coverage for orthopedic shoes and corrective features. 405 IAC 5-37-3 to add dentists to the list of practitioners that may provide smoking cessation counseling services. Makes additional technical conforming changes. Effective 30 days after filing with the secretary of state.

<b>405 IAC 5-2-17</b>	<b>405 IAC 5-19-7</b>
<b>405 IAC 5-3-4</b>	<b>405 IAC 5-19-10</b>
<b>405 IAC 5-3-11</b>	<b>405 IAC 5-29-1</b>
<b>405 IAC 5-7-1</b>	<b>405 IAC 5-37-3</b>
<b>405 IAC 5-8-3</b>	

SECTION 1. 405 IAC 5-2-17 IS AMENDED TO READ AS FOLLOWS:

**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 meets current professional standards commonly held to be applicable to the case. 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)*

SECTION 2. 405 IAC 5-3-4 IS AMENDED TO READ AS FOLLOWS:

**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 ~~based upon current professional standards held applicable.~~ **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)*

SECTION 3. 405 IAC 5-3-11 IS AMENDED TO READ AS FOLLOWS:

**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 ~~based upon current professional standards commonly held to be applicable to the case:~~ **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)*

SECTION 4. 405 IAC 5-7-1 IS AMENDED TO READ AS FOLLOWS:

#### **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 3-3;~~ **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) A prior authorization request will be rejected~~ When there is insufficient information submitted to render a decision, **it 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. ~~A rejected request may be resubmitted with~~ **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)*

SECTION 5. 405 IAC 5-8-3 IS AMENDED TO READ AS FOLLOWS:

#### **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) ~~A~~ **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) ~~A second consultation provided by the same consultant physician to the same recipient must be for a new unrelated condition and clearly documented as such by the requesting physician.~~ **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*)

SECTION 6. 405 IAC 5-19-7 IS AMENDED TO READ AS FOLLOWS:

**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*)

SECTION 7. 405 IAC 5-19-10 IS AMENDED TO READ AS FOLLOWS:

**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. ~~(a)~~ Medicaid reimbursement is available for the following:

- (1) Braces for the leg, arm, back, and neck. ~~for recipients of all ages.~~
- (2) Orthopedic shoes. ~~for recipients over twenty-one (21) years of age with severe diabetic foot disease or if the orthopedic shoe is connected to a brace.~~
- (3) Corrective features built into shoes such as heels, lifts, and wedges. ~~only for recipients under twenty-one (21) years of age.~~

~~(b) All items specified in subsection (a) must be ordered in writing by a physician or podiatrist and be prior authorized by the office.~~ (*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*)

SECTION 8. 405 IAC 5-29-1, AS AMENDED AT 24 IR 15, SECTION 2, IS AMENDED TO READ AS FOLLOWS:

**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 ~~medically~~ **medially** [*sic.*] reasonable or necessary ~~according to current professional standards commonly held to be applicable to the case.~~ **as defined in this article.**
- (2) Services provided outside the scope of a provider's license, registration, certification, or other authority to practice under state or federal law.
- (3) Experimental drugs, treatments, or procedures, and all related services.

- (4) Any new product, service, or technology not specifically covered in this article. The product, service, or technology will remain a noncovered product, service, or technology until such time as the office authorizes the coverage of the product, service, or technology. This subdivision does not apply to legend drugs.
- (5) Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental.
- (6) Services for the remediation of learning disabilities.
- (7) Treatments or therapies of an educational nature.
- (8) Experimental radiological or surgical or other modalities and procedures, including, but not limited to, the following:
  - (A) Acupuncture.
  - (B) Biofeedback therapy.
  - (C) Carbon dioxide five percent (5%) inhalator therapy for inner ear disease.
  - (D) Hyperthermia.
  - (E) Hypnotherapy.
- (9) Hair transplants.
- (10) Fallopian tuboplasty (reanastomosis of the fallopian tubes) for infertility or vasovasostomy (reanastomosis of the vas ~~deferens~~ **deferens**). *[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) ~~Multifaceted~~ **Multifaceted** *[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)*

SECTION 9. 405 IAC 5-37-3 IS AMENDED TO READ AS FOLLOWS:

**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)*

*LSA Document #01-58(F)*

*Notice of Intent Published: 24 IR 1687*

*Proposed Rule Published: May 1, 2001; 24 IR 2518*

*Hearing Held: June 6, 2001*

*Approved by Attorney General: September 28, 2001*

*Approved by Governor: October 2, 2001*

*Filed with Secretary of State: October 3, 2001, 9:47 a.m.*

*Incorporated Documents Filed with Secretary of State: None*