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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #04-178

DIGEST

Amends 405 IAC 1-1-5 and 405 IAC 1-1.5-2 to specify that a hospital has 60 days after the date of an overpayment notice to repay the overpayment or to file an appeal to comply with P.L.78-2004. Amends 405 IAC 5-1-5 to update language regarding coding sources. Amends 405 IAC 5-3-13 to eliminate the prior authorization requirement for certain services and to specify that orthodontic procedures for members under 21 years of age for cases of craniofacial deformity or cleft palate are subject to prior authorization. Amends 405 IAC 5-9-1 to allow Medicaid reimbursement for evaluation and management services for 50 office visits per rolling 12 month period without prior authorization. Amends 405 IAC 5-19-1(h) to allow for reimbursement for medical supplies in quantities greater than a one-month supply if the recipient is a Medicare beneficiary and if Medicare allows reimbursement for that quantity. Amends 405 IAC 5-19-10 to specify that Medicaid reimbursement is available for corrective shoe features. Amends 405 IAC 5-26-5 to correct an Indiana Administrative Code reference. Effective 30 days after filing with the secretary of state.

405 IAC 1-1-5	**405 IAC 5-9-1**
405 IAC 1-1.5-2	**405 IAC 5-19-1**
405 IAC 5-1-5	**405 IAC 5-19-10**
405 IAC 5-3-13	**405 IAC 5-26-5**

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

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

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:

(A) an inaccurate description of services or an inaccurate usage of procedure codes;

~~(7) overpayment resulted from~~ **(B)** 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~~ **(C)** duplicate billing; **or**

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

~~(10)~~ **(7)** 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:

(A) be completed within one hundred eighty (180) days of the date of appeal; and ~~must~~

(B) 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)~~ **(f)** 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).~~ **IC 12-15-13-3(e)(1).**

~~(h)~~ **(g)** 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).~~ **IC 12-15-13-3(e)(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:

(1) accrue from the date of the overpayment to the provider; and ~~shall~~

(2) 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)~~ **(h)** 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:

(1) 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~~ **and**

(2) at the rate of interest set out in ~~IC 12-15-13-3(f)(2).~~ **IC 12-15-13-3(e)(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)~~ **(i)** 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)~~ **(j)** 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)~~ **(k)** Nothing in this section shall be construed to preclude the office from revising a provider's rate of reimbursement under 405 IAC 1-12, **405 IAC 1-14.5,** or ~~405 IAC 1-14.1~~ **405 IAC 1-14.6** 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.*

SECTION 2. 405 IAC 1-1.5-2 IS AMENDED TO READ AS FOLLOWS:

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)~~ **(2)** 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~~ **before** filing an appeal request.

(c) An appeal request must state facts demonstrating that **the petitioner is:**

(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; **and**
(2) with respect to each finding, action, or determination:
(A) why the provider believes that the office's determination was in error; and
~~(3) with respect to each finding, action, or determination,~~ **(B)** 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)~~ **(f)** 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 **the:**
(1) ~~the~~ specific findings, action, or determination of the office; or
(2) ~~the~~ reason or rationale supporting the provider's appeal.

~~(h)~~ **(g)** 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)~~ **(h)** 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)~~ **(i)** 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)~~ **(j)** Notwithstanding subsections (d) through ~~(g),~~ **(f),** 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)*

SECTION 3. 405 IAC 5-1-5 IS AMENDED TO READ AS FOLLOWS:

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~~ **The Centers for Medicare and Medicaid Service's** Common Procedure Coding System (HCPCS) and International Classification of Diseases–9th Revision–Clinical Modification (ICD-9-CM) codes shall be used by providers when submitting medical claims to the contractor for adjudication. American Dental Association codes **from the Current Dental Terminology Users Manual (CDT-4)** shall be used by providers when submitting dental claims to the contractor for adjudication. **Providers must use the most up-to-date versions of these coding classifications.**

(c) Medicaid claims filed by pharmacy providers on the drug claim form/format must utilize an appropriately configured National Drug Code (NDC), Universal Package Code (UPC), Health Related Item Code (HRI), or state-assigned code. When services are billed that have been prior authorized, the procedure code from the prior authorization form shall be utilized. On UB-92 forms, use

the appropriate UB-92 Revenue Codes, as well as the narrative descriptions of services, and the appropriate diagnostic and procedure code contained in ICD-9-CM.

(d) Documentation in the medical records maintained by the provider must substantiate the medical necessity for the procedure or service and the code selected or description given by the provider. This is subject to postpayment audit and review. *(Office of the Secretary of Family and Social Services; 405 IAC 5-1-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 4. 405 IAC 5-3-13, AS AMENDED AT 27 IR 2244, SECTION 1, IS AMENDED TO READ AS FOLLOWS:

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)~~ **(9)** Home health services.
~~(12)~~ **(10)** Maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures.
~~(13)~~ **(11)** Temporomandibular joint surgery.
~~(14)~~ **(12)** 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)~~ **(13)** Weight reduction surgery, including gastroplasty and related gastrointestinal surgery.
~~(21)~~ **(14)** Any procedure ordinarily rendered on an outpatient basis, when rendered on an inpatient basis.
~~(22)~~ **(15)** All dental admissions.
~~(23) Stress electrocardiograms except for medical conditions.~~
~~(24)~~ **(16)** Brand medically necessary drugs.
~~(25)~~ **(17)** Other drugs as specified in accordance with 405 IAC 5-24-8.5.
~~(26)~~ **(18)** Psychiatric inpatient admissions, including admissions for substance abuse.
~~(27)~~ **(19)** Rehabilitation inpatient admissions.
~~(28)~~ **(20)** Assertive community treatment intensive case management as provided under 405 IAC 5-21-1.
(21) Orthodontic procedures for members under twenty-one (21) years of age for cases of craniofacial deformity or cleft palate.
~~(29)~~ **(22)** As otherwise specified in this article.
If any of the surgeries listed in this section are performed during a hospital stay for another condition, prior authorization is required for the surgical procedure.

(b) Requests for prior authorization for the surgical procedures in this section will be reviewed for medical necessity on a case-by-case basis in accordance with this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3306; filed Sep 1, 2000, 2:16 p.m.: 24 IR 14; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1613; filed Feb 26, 2004, 3:45 p.m.: 27 IR 2244)*

SECTION 5. 405 IAC 5-9-1 IS AMENDED TO READ AS FOLLOWS:

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)~~ **fifty (50)** per ~~year~~ **rolling twelve (12) month period per** recipient, per provider without prior authorization and subject to the restrictions in section 2 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-9-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 6. 405 IAC 5-19-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-1 Medical supplies
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 1. (a) Medical and surgical supplies (medical supplies) are:
(1) disposable items that are not reusable and must be replaced on a frequent basis; ~~Medical supplies are~~
(2) used primarily and customarily to serve a medical purpose; ~~are~~
(3) generally not useful to a person in the absence of an illness or injury; and ~~are~~
(4) covered only for the treatment of a medical condition.
Reimbursement is available for medical supplies subject to the restrictions listed in this section.

(b) Medical supplies include, but are not limited to, the following items:
(1) Antiseptics and solutions.
(2) Bandages and dressing supplies.
(3) Gauze pads.
(4) Catheters.
(5) Incontinence supplies.
(6) Irrigation supplies.
(7) Diabetic supplies.
(8) Ostomy supplies.
(9) Respiratory and tracheotomy supplies.

(c) Covered medical supplies do not include the following items:
(1) Drug products, either legend or nonlegend.
(2) Sanitary napkins.
(3) Cosmetics.
(4) Dentifrice items.
(5) Tissue.
(6) Nonostomy deodorizing products, soap, disposable wipes, shampoo, or other items generally used for personal hygiene.

(d) Providers shall bill in accordance with the instructions set forth in the Indiana health coverage programs manual or update bulletins.

(e) Incontinence supplies, including underpads, incontinent briefs and liners, diapers, and disposable diapers, are covered ~~subject to the following limitations:~~ **only:**
(1) ~~The supplies in this subsection are covered only~~ in cases of documented necessity, at a rate determined by the office; **and**
(2) ~~The supplies in this subsection are covered only~~ for recipients three (3) years of age or older.

(f) All medical supplies must be ordered in writing by a physician or dentist.

(g) Medical supplies that are included in facility reimbursement, or that are otherwise included as part of reimbursement for a

medical or surgical procedure, are not separately reimbursable to any party. All covered medical supplies, whether for routine or nonroutine use, are included in the per diem for nursing facilities, even if the facility does not include the cost of medical supplies in their facility cost reports.

(h) Reimbursement is not available for medical supplies dispensed in quantities greater than a one (1) month supply for each calendar month, except when:
(1) packaged by the manufacturer only in larger quantities; **or**
(2) the recipient is a Medicare beneficiary and Medicare allows reimbursement for a larger quantity.

(i) Medical supplies shall be for a specific medical purpose, not incidental or general purpose usage.

(j) Reimbursement for medical supplies is equal to the lower of the following:
(1) The provider's submitted charges, not to exceed the provider's usual and customary charges.
(2) The Medicaid allowable fee schedule amount as determined under this section.

(k) The Medicaid allowable fee schedule amount to be effective on the effective date of this rule is the base statewide fee schedule amount equal to the lower of the Medicaid fee schedule amount in effect during **state fiscal year** (SFY) 2001 or the amount determined as follows:
(1) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then subdivision (2).
(2) The Indiana Medicare fee schedule amount adjusted by a multiplier of no less than eight-tenths (.8), if available. If this amount is not available, then subdivision (3).
(3) The weighted median of providers' usual and customary charges adjusted by a multiplier of no less than eight-tenths (.8), if available. If this amount is not available, then subdivision (4).
(4) The Medicaid fee schedule amount in effect during ~~state fiscal year~~ **SFY** 2001, if available. If this amount is not available, then subdivision (5).
(5) The average Indiana Medicaid payment amount per item during ~~state fiscal year~~ **SFY** 2001.

(l) The office may review the statewide fee schedule and adjust it as necessary using the:
(1) Medicare fee schedule; **and**
(2) the providers':
(A) usual and customary charges; and ~~the providers'~~
(B) acquisition cost information;
subject to ~~subsections~~ **subsection** (k)(1) through (k)(5). Any adjustments shall be made effective no earlier than permitted under IC 12-15-13-6.

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

(n) Providers must include their usual and customary charge for each medical supply item when submitting claims for reimbursement. Providers shall not use the Medicaid calculated allowable fee schedule amount for their billed charge unless it is less than or equal to the amount charged by the provider to the general public. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; filed Sep 27, 1999, 8:55 a.m.: 23 IR 313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 10, 2003, 11:01 a.m.: 26 IR 1901)*

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. Medicaid reimbursement is available for the following:
(1) Braces for the leg, arm, back, and neck.
(2) Orthopedic shoes **and corrective shoe features.**

(3) Corrective features built into shoes, such as heels, lifts, and wedges.
(Office of the Secretary of Family and Social Services; 405 IAC 5-19-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 379)

SECTION 8. 405 IAC 5-26-5 IS AMENDED TO READ AS FOLLOWS:

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.~~ **405 IAC 5-17.**
(2) When a podiatrist prescribes or supplies corrective features built into shoes, such as heels, lifts, and wedges, for a recipient under twenty-one (21) years of age.
(3) When a podiatrist fits or supplies orthopedic shoes for a recipient with severe diabetic foot disease subject to the restrictions and limitations outlined 405 IAC 5-19.

(b) Medicaid reimbursement is available for the following surgical procedures without prior authorization:
(1) Surgical cleansing of the skin.
(2) Drainage of skin abscesses.
(3) Drainage or injections of a joint or bursa.
(4) Trimming of skin lesions.
Reimbursement for other surgical procedures performed within the scope of the podiatrist's license is available subject to the prior authorization requirements of 405 IAC 5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 5-26-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3349; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on October 27, 2004 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room C, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments concerning Medicaid overpayment appeals and medical policy. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Cheryl Sullivan
Secretary
Office of the Secretary of Family and Social Services