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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #06-5

DIGEST

Amends 405 IAC 5-14-1 and 405 IAC 5-14-3 to place limitations on dental services for adults that are in accordance with HEA 1001-2005, SECTION 239, and amends rules regarding coverage for diagnostic services. Effective 30 days after filing with the Secretary of State.

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

There were approximately 1,500 participating dental providers in the Indiana Medicaid Program during calendar year 2005. Potentially, any of these providers could provide services to adults and could be impacted by this rule change.

There would be no reporting requirements imposed on providers associated with this rule change. There would be a minor administrative impact in that providers would now have to obtain prior authorization for certain dental services. Previously, these services did not require prior authorization before claims could be submitted for payment.

Obtaining prior authorization requires completion of a form denoting the service and the medical (or dental) reason for the service. This is then sent to the Indiana Medicaid Medical Policy Contractor who handles prior authorization reviews. Dentists would receive a response by not later than 10 working days (plus four days mailing time) of the results of the prior authorization review. If prior authorization is given, the service can be provided and billed. If the authorization request is denied, the provider may request an administrative review and if denied, a hearing. This process is no different from the existing process for prior authorization transactions. Providers will receive advance notice that these services will be subject to prior authorization and they receive written instructions on implementing the change.

There is no less intrusive or costly alternative to achieve the purpose of this rule. Most providers already have experience with prior authorization procedures for other services provided to Medicaid recipients. The total annual estimated economic impact to all affected providers under this rule is $153,000. This was calculated based on an annual spending by Medicaid of $5.1 million on dental services that will now require prior authorization. It is estimated that prior authorization of these services will cause a drop in the provision of unnecessary services (approximately 3%), resulting in a savings to the state of $153,000. Spread over the pool of dental providers, each provider is expected to be impacted approximately $100 per year due to this change.

SECTION 1 of this document is the result of a mandated change by legislation and the agency has no discretion other than to move forward with this change. No alternatives to making this change are known at this time. SECTION 2 of this document expands the providers ability to chose the best service for the client based on the provider's observations. It imposes neither new costs or requirements on providers. As such, SECTION 2 of this document does not fall within the purview of IC 4-22-2.1-5.

405 IAC 5-14-1
405 IAC 5-14-3

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

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

Sec. 1. (a) Medicaid reimbursement is available only for those dental services listed in section 2 of this rule subject to the limitations set out in this rule.

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

(1) will be listed and published in a provider bulletin; and
(2) may be updated by the office as needed.
A provider bulletin issued under this subsection shall be effective no earlier than permitted under IC 12-15-13-6.

(c) For those recipients twenty-one (21) years of age and over, all covered services will require prior authorization except the following:
(1) Diagnostic and preventative services.
(2) Direct restorations.
(3) Treatment of lesions.
(4) Periodontal services for the following immuno-compromised individuals:
(A) Transplant patients.
(B) Pregnant women.
(C) Diabetic patients.
(5) Extractions.
(6) Emergency and trauma care.
(Office of the Secretary of Family and Social Services; 405 IAC 5-14-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1546)

SECTION 2. 405 IAC 5-14-3 IS AMENDED TO READ AS FOLLOWS:

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

Sec. 3. Medicaid reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs, and emergency treatments, with the following limitations.
(1) Either **a** full mouth series ~~radiographs~~ or panorex is limited to one (1) set per recipient every three (3) years.
(2) Bitewing ~~and intraoral~~ radiographs are limited to one (1) set per recipient every twelve (12) months. One (1) set of bitewings is defined as ~~a total of~~ **either:**
(A) four (4) ~~single~~ **horizontal** films; **or**
(B) seven (7) to eight (8) vertical films.
(3) Intraoral radiographs are limited to one (1) first film and seven (7) additional films, **per recipient every twelve (12) months.**
(4) Temporomandibular joint ~~arthograms,~~ **arthrograms,** other temporomandibular films, tomographic surveys, and cephalometric films are no longer covered in a dental office.
~~(3)~~ **(5)** A comprehensive or detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider, with an annual limit of two (2) per recipient.
~~(4)~~ **(6)** A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient, any provider.
~~(5)~~ **(7)** Mouth gum cultures and sensitivity tests are not covered.
~~(6)~~ **(8)** Oral hygiene instructions:
(A) are reimbursed in the Medicaid payment allowance for diagnostic services; and
(B) may not be billed separately to Medicaid.
~~(7)~~ **(9)** Payment for the writing of prescriptions:
(A) is included in the reimbursement for diagnostic services; and
(B) may not be billed separately to Medicaid.
(Office of the Secretary of Family and Social Services; 405 IAC 5-14-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2863)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on June 22, 2006 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 2, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments concerning the Office Medicaid Policy and Planning's rule to place limitations on dental services and amend coverage for diagnostic services.
SECTION 1 of this document is being implemented in accordance with HEA 1001-2005, SECTION 239; SECTION 2 of this document is being proposed to expand provider options when providing covered services.

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.

E. Mitchell Roob Jr.
Secretary
Office of the Secretary of Family and Social Services