TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #18-125(F)

DIGEST

Amends 405 IAC 5-3-5 to remove the requirement for rehabilitative potential for wheelchairs for child recipients in a nursing facility in accordance with IC 12-15-5-12. Amends 405 IAC 5-19-1 and 405 IAC 5-19-2 to update and clarify definitions and terminology. Adds 405 IAC 5-19-2.5 to implement the requirement for documentation of a face-to-face encounter for home health durable medical equipment (DME) items in accordance with 42 CFR 440.70(f). Amends 405 IAC 5-19-7 to revise state regulations for prior authorization to implement the requirement for documentation of a face-to-face encounter for home health DME items in accordance with 42 CFR 440.70(f) and to remove the requirement for rehabilitative potential for wheelchairs for child recipients in a nursing facility in accordance with IC 12-15-5-12. Amends 405 IAC 5-19-13 to update and clarify definitions and terminology. Amends 405 IAC 5-19-18, 405 IAC 5-26-5, and 405 IAC 5-26-6 to comply with court order requiring coverage of orthotics regardless of age. Effective 30 days after filing with the Publisher.

405 IAC 5-3-5; 405 IAC 5-19-1; 405 IAC 5-19-2; 405 IAC 5-19-2.5; 405 IAC 5-19-7; 405 IAC 5-19-13; 405 IAC 5-19-18; 405 IAC 5-26-5; 405 IAC 5-26-6

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

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

Authority: 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 authorization request and available for audit purposes.

(b) For services requiring a written request for authorization, a properly completed Medicaid prior 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 signature of the provider. The agency will accept any of the following:
(A) A prior authorization request form bearing the original signature of the provider.
(B) A scanned or faxed copy of an originally signed prior authorization request form described in clause (A).
(C) An original prior authorization request form bearing the provider's signature stamp.
(D) A scanned or faxed copy of a prior authorization request form described in clause (C).
(E) The electronic signature of the provider submitted through the prior authorization electronic management system according to agency policy.
(3) Diagnosis and related information.
(4) Services or supplies requested with appropriate CPT, HCPCS, or American Dental Association 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), **except as set forth in 405 IAC 5-19-7(5).**
(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 that the treatment was medically necessary.

(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.
(15) Diagnosis code.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3304; filed Sep 27, 1999, 8:55 a.m.: 23 IR 308; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Oct 26, 2015, 9:10 a.m.: 20151125-IR-405150070FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

SECTION 2. 405 IAC 5-19-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-1 Medical supplies

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

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

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

(c) Covered medical supplies do not include the following:
(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 for medical supplies in accordance with the instructions set forth in the Indiana health coverage programs manual, bulletins, or banner pages.

(e) Incontinence supplies, including underpads, incontinent briefs and liners, diapers, and disposable diapers, are covered only:
(1) in cases documented as medically necessary at a rate determined by the office; and
(2) for members 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 member is a Medicare member 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 is the Medicaid fee schedule amount in effect on June 30, 2011. If this amount is not available, the Medicaid allowable shall be the amount determined as follows:
(1) The Indiana Medicare fee schedule amount adjusted by a multiplier of eight-tenths (0.8), if available. If this amount is not available, then subdivision (2).
(2) 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 (3).
(3) The manufacturer's suggested retail price adjusted by a multiplier of seventy-five hundredths (0.75). If this amount is not available, then subdivision (4).
(4) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2).

(l) The office may review the statewide fee schedule and adjust it as necessary, subject to subsection (k)(1) through (k)(4). Any adjustments shall be made effective no earlier than permitted under IC 12-15-13-6.

(m) Providers must include their usual and customary charge for each medical supply item when submitting claims for reimbursement. Providers shall not use the Medicaid calculated allowable fee schedule amount for their billed charge unless it is less than or equal to the amount charged by the provider to the general public.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; filed Sep 27, 1999, 8:55 a.m.: 23 IR 313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 10, 2003, 11:01 a.m.: 26 IR 1901; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2133; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jul 5, 2011, 1:39 p.m.: 20110803-IR-405110159FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

SECTION 3. 405 IAC 5-19-2 IS AMENDED TO READ AS FOLLOWS:

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

Authority: 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 member in the absence of **a disability,** illness, or injury. ~~Items including, but not limited to, the following are examples of DME and may be authorized when medically necessary:~~
~~(1) Hospital beds.~~
~~(2) Wheelchairs.~~
~~(3) Iron lungs.~~
~~(4) Respirators.~~
~~(5) Oxygen tents.~~
~~(6) Commodes.~~

~~(7) Traction equipment.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3329; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

SECTION 4. 405 IAC 5-19-2.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-19-2.5 "Durable medical equipment" or "DME" requiring a face-to-face encounter

Authority: 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. 2.5. Documentation of a face-to-face encounter for home health services in accordance with 42 CFR 440.70(f) is required for the following specified items:

(1) Specified items may include, but are not limited to, the following:
- **(A) Decubitus care equipment.**
- **(B) Hospital beds and accessories.**
- **(C) Oxygen and related respiratory equipment.**
- **(D) Humidifiers, compressors, and nebulizers.**
- **(E) Monitoring devices.**
- **(F) Patient lifts.**
- **(G) Compression devices.**
- **(H) Ultraviolet light.**
- **(I) Nerve stimulators and devices.**
- **(J) Infusion supplies.**
- **(K) Traction equipment.**
- **(L) Wheelchairs and wheelchair accessories.**
- **(M) Whirlpool equipment.**
- **(N) Speech generating devices.**

(2) Face-to-face encounters shall meet the requirements set forth in 42 U.S.C. 1395m(a)(11)(B)(ii).

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-2.5; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

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

405 IAC 5-19-7 Prior authorization criteria

Authority: 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 office, using all of the following criteria:

(1) The item must be medically necessary 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 office based on the least expensive option available to meet the member's needs.

(4) Documentation of a face-to-face encounter for home health services in accordance with 42 CFR 440.70(f) is required for specified items in accordance with section 2.5 of this rule.

(5) Rehabilitation potential is not required for prior authorization requests for specialized wheelchairs if the member is a resident of a nursing facility designated by the office as a children's nursing facility as defined at 405 IAC 1-14.6-2(k).

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 379; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.:

20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

SECTION 6. 405 IAC 5-19-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-13 Hearing aids; purchase

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

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 member is to be fitted with a hearing amplification device by either ~~the~~ **a licensed** 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.

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

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

(7) Medicaid reimbursement of hearing aids is based on the **most recently published** fee schedule ~~amount~~ in effect. ~~on June 30, 2011.~~ If this amount is not available, then use clause (A) as follows:

(A) 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 use clause (B).

(B) The manufacturer's suggested retail price adjusted by a multiplier of seventy-five hundredths (0.75).

(8) Reimbursement of a hearing aid dispensing fee is also available subject to the following requirements:

(A) Is a one-time dispensing fee.

(B) May be billed only in conjunction with a hearing aid procedure code that has an established fee schedule amount.

(C) Includes all services related to the initial fitting and adjustment of the hearing aid, orientation of the patient, and instructions on the hearing aid.

(9) Reimbursement for binaural hearing aids will be twice the monaural rate.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; filed Sep 27, 1999, 8:55 a.m.: 23 IR 313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

SECTION 7. 405 IAC 5-19-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-18 Noncovered durable medical equipment

Authority: 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 members 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 member with severe diabetic foot disease.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-18; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3332; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

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

405 IAC 5-26-5 Prior authorization

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

Sec. 5. (a) Prior authorization by the office is required for the following:
(1) Hospital stays as outlined in 405 IAC 5-17.
(2) When a podiatrist prescribes or supplies corrective features built into shoes, such as heels, lifts, and wedges. ~~for a member under twenty-one (21) years of age.~~
~~(3) When a podiatrist fits or supplies orthopedic shoes for a member with severe diabetic foot disease subject to the restrictions and limitations outlined 405 IAC 5-19.~~

(b) Medicaid reimbursement is available for the following surgical procedures without prior authorization:
(1) Surgical cleansing of the skin.
(2) Drainage of skin abscesses.
(3) Drainage or injections of a joint or bursa.
(4) Trimming of skin lesions.
Reimbursement for other surgical procedures performed within the scope of the podiatrist's license is available subject to the prior authorization requirements of 405 IAC 5-3.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3349; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2134; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

SECTION 9. 405 IAC 5-26-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-26-6 Orthotic services

Authority: 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~~ **for** orthotic services. ~~as covered by Medicare for all eligible members receiving both Medicare and Medicaid.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3349; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; filed Jul 23, 2018, 3:32 p.m.: 20180822-IR-405180125FRA)

LSA Document #18-125(F)
Notice of Intent: 20180307-IR-405180125NIA
Proposed Rule: 20180502-IR-405180125PRA
Hearing Held: May 24, 2018
Approved by Attorney General: July 13, 2018
Approved by Governor: July 23, 2018
Filed with Publisher: July 23, 2018, 3:32 p.m.
Documents Incorporated by Reference: 42 CFR 440.70; 42 U.S.C. 1395m
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Posted: 08/22/2018 by Legislative Services Agency
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