TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #18-251

DIGEST

Amends 405 IAC 1-1-1, 405 IAC 1-1-3, 405 IAC 1-1-15, and 405 IAC 1-17-18 to update definitions. Adds 405 IAC 1-1.4 to update and streamline the program integrity rule. Amends 405 IAC 2-3.3-4 and 405 IAC 5-21.7-14 to align with these changes. Repeals 405 IAC 1-1-4, 405 IAC 1-1-5, 405 IAC 1-1-5.1, 405 IAC 1-1-6, 405 IAC 1-1.5, 405 IAC 1-5, and 405 IAC 5-4. Effective 30 days after filing with the Publisher.

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

405 IAC 1-1-1; 405 IAC 1-1-3; 405 IAC 1-1-4; 405 IAC 1-1-5; 405 IAC 1-1-5.1; 405 IAC 1-1-6; 405 IAC 1-1-15; 405 IAC 1-1.4; 405 IAC 1-1.5; 405 IAC 1-5; 405 IAC 1-17-18; 405 IAC 2-3.3-4; 405 IAC 5-4; 405 IAC 5-21.7-14

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

405 IAC 1-1-1 Definitions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-6-10; IC 12-13-7-3; IC 12-15; IC 16-19; IC 16-21; IC 16-28; IC 16-29-4-2

Sec. 1. ~~(a)~~ The **following** definitions in this section apply throughout this article:
~~(b)~~ **(1)** "Attending physician" means a physician who is responsible for developing and maintaining the plan of care for a Medicaid patient.
~~(c)~~ **(2)** "CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the United States Department of Health and Human Services.
~~(d)~~ **(3)** "CRF/DD" or "CRFs/DD" means a community residential facility or facilities for the developmentally disabled.
~~(e)~~ **(4)** "CRMNF" means a comprehensive rehabilitative management needs facility as defined in 460 IAC 9-1-2.
~~(f)~~ **(5)** "ICF/IID" or "ICFs/IID" means an institution or institutions for individuals with intellectual disabilities, as described in IC 16-29-4-2, or a medical institution or that portion thereof providing such care, which is qualified as such an institution pursuant to the provisions of Title XIX of the Social Security Act.
~~(g)~~ **(6)** "IMFCU" means the Medicaid fraud control unit established by the Indiana attorney general under the authority of IC 4-6-10 et seq.
~~(h)~~ **(7)** "ISDH" means the Indiana state department of health as defined in IC 16-19.
~~(i)~~ **(8)** "Medicaid" means that program described by IC 12-15 and this title, in which the office administers benefits and makes payments to providers for covered services provided to members.
~~(j)~~ **(9)** "Member" means an individual who has been determined by the office to be eligible for payment of covered services pursuant to IC 12-15.
~~(k)~~ **(10)** "Nursing facility" means a comprehensive care facility licensed under IC 16-28, or a hospital based long term care facility licensed under IC 16-21 and enrolled as a Medicaid provider.
~~(l)~~ **(11)** "Nursing facility services" has the meaning set forth in 405 IAC 5-31-1.1.
~~(m)~~ **(12)** "Office" means the Indiana family and social services administration and its offices, divisions, or designees.
~~(n)~~ **(13)** "Parameter" means the maximum amount or duration, or both, of a service within appropriate limits for which payment may be made without prior authorization or exception due to medical necessity or contraindications.
~~(o)~~ **(14)** "Prior authorization" has the meaning set forth in 405 IAC 5-2-20.
~~(p)~~ **(15)** "Provider" means an individual, state agency, local agency, corporate entity, or business entity that has been enrolled in Medicaid pursuant to ~~405 IAC 5-4~~. **405 IAC 1-1.4-3.**
~~(q)~~ **(16)** "Provider manual" means the interpretive document or documents issued by the office to providers to inform them of their obligations under Medicaid to which they must conform to retain their provider status and receive payment for appropriate services, and to provide them essential information for understanding Medicaid as it relates to the services for which they are qualified to provide under the state statutes.
~~(r)~~ **(17)** "Third party" means an insurer, individual, institution, corporation, or 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.

~~(s)~~ **(18)** "Usual and customary charge" means the amount a provider offers to charge the general public for a service or supply, including applicable offered discounts. General public does not include individuals who are enrolled in or a member of an insurance plan that covers the services or supplies in question, or receive a discount of the services or supplies through a program with selective criteria that disqualify certain individuals from eligibility in the program.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-101; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 248; filed Sep 29, 1982, 3:19 p.m.: 5 IR 2321; filed Mar 14, 1986, 4:35 p.m.: 9 IR 1856; 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) 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.

SECTION 2. 405 IAC 1-1-3 IS AMENDED TO READ AS FOLLOWS:

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

Authority: 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~~ **For dates of service on or before December 31, 2018,** provider claims for payment for services rendered to members must be originally filed with the office within twelve (12) months of the date of the provision of the service.

(b) For dates of service on or after January 1, 2019, provider claims for payment for services rendered to members must be originally filed with the office within one hundred eighty (180) days of the date of the provision of the service.

(c) A provider who is dissatisfied with the amount of reimbursement may appeal under the provisions of ~~405 IAC 1-1.5~~. **405 IAC 1-1.4.** 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 office; or
(3) submit a written request to the office, stating why the provider disagrees with the denial or amount of reimbursement.

~~(b)~~ **(d)** All requests for payment adjustments or reconsideration, or both, of a claim that has been denied must be submitted to the office 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 office. ~~All~~

(e) For dates of service on or before December 31, 2018, claims filed after twelve (12) months of the date of the provision of the service ~~as well as~~ **shall be denied for payment unless a waiver has been granted. For dates of service on or after January 1, 2019, claims filed after one hundred eighty (180) days of the date of the provision of the service shall be denied for payment unless a waiver has been granted.** Claims filed after sixty (60) days of the date of notification that the claim was paid or denied shall be ~~rejected~~ **denied** for payment unless a waiver has been granted. In extenuating circumstances a waiver of the filing limit may be authorized by the office 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) office 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)~~ **(f)** The fact that the provider was unaware the member 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 member refused or was physically unable to provide the member's Medicaid number.

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

(3) The provider billed Medicaid, 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 is subsequently determined to be eligible, 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 member 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 office. Such situations will be reviewed on an individual basis by the office to ascertain if the provider made a good faith effort to enroll and submit claims in a timely manner.

~~(d)~~ **(g)** All claims filed for reimbursement shall be reviewed prior to payment by the office 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)~~ **(h)** Medicaid is only liable for the payment of claims filed by providers who were enrolled providers at the time the service was rendered and for services provided to persons who were enrolled in Medicaid as eligible members 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. Non-enrolled providers giving the retroactive service must file a provider application retroactive to the beginning date of eligible service and meet provider enrollment requirements during the retroactive period. A claim for services which requires prior authorization by the office provided during the retroactive period will not be paid unless such services have been reviewed and approved by the office prior to payment. The claim will not be paid if the services provided are outside the service parameters as established by the office.

~~(f)~~ **(i)** Third party payment is as follows:

(1) Resources from health insurance plans available to the member 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 Worker's Compensation. A provider of services to a member shall not submit a claim for reimbursement by Medicaid until the provider 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 office, 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 office required when such third party resources become available.

(2) Third party payments applied to the member'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 office according to the requirements of federal and state laws governing rate setting for Medicaid services and shall be accepted as party payor.

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

~~(h)~~ **(k)** No Medicaid reimbursement shall be available for services provided outside the parameters of a restricted status. ~~(see section 6 of this rule).~~

~~(i)~~ **(l)** A Medicaid provider shall not collect from a Medicaid member or from the family of the Medicaid member any portion of the charge for a Medicaid covered service which is not reimbursed by Medicaid 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 a.m.: Rules and Regs. 1979, p. 250; filed Oct 7, 1982, 3:54 p.m.: 5 IR 2345; filed Mar 14, 1986, 4:35 p.m.: 9 IR 1857; filed Mar 15, 1988, 1:59 p.m.: 11 IR 2850; 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; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA) 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.

SECTION 3. 405 IAC 1-1-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1-15 Third party liability; definitions

Authority: 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 this section:
(1) "Final settlement" means payment of money from a third party liable for the injury, illness, or disease of a member 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 office's claim bearing:
(A) a certification that the person named in the notice is a member of Medicaid; and
(B) the signature of an authorized Medicaid employee.
(3) "Certification" means a statement authenticated by the seal of the office.
(4) "Office's claim" means a statement of Medicaid payments made by the office for any Medicaid member 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 or Medicaid, or both, 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 office 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 member when the office provides Medicaid. Circumstances under which the office 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 office erroneously made payment before the third party or all other parties had made payment;
(5) a court order has been issued; or
(6) the member asserts a claim against a third party who is or may be liable for the injury, illness, or disease of a Medicaid applicant or member.

(c) The office, acting in behalf of the Medicaid member, may initiate an action against a third party that is or may be liable for the injury, illness, or disease of a Medicaid member because:
(1) the member has not done so; and
(2) the time remaining under the statute of limitations for the action is six (6) months or less.

(d) In perfecting its lien, the office shall take the following action before the third party makes final settlement to the Medicaid member as total compensation for the member's injury, illness, or disease:
(1) serve notice:
(A) to third parties in the manner described in subsection (e); and/or
(B) to insurers in the manner described in either subsection (e)(3)(C) or (f) as deemed appropriate by the office; 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 office'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 office may perfect its lien by serving notice to third parties in the following manner:
(1) Filing a written notice in the Marion County Court stating the following:

(A) The name and address of the member.
(B) That the individual is eligible for Medicaid.
(C) The name of the person or third party alleged to be liable to the injured, ill, or diseased member.
(2) Sending a copy of the notice filed in the Marion County 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 member.
(B) The member's attorney.
(C) The insurer or other third parties.

(f) The office may serve notice to insurers and/or initiate the coordination of benefits by mailing a notice to the insurer that:
(1) is on state letterhead;
(2) is sent by certified mail; and
(3) includes, if reasonably available to the office, the following information pertaining to the Medicaid member:
(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 subsection (e)(3)(C) or (f) prior to making payment on a claim, and the insurer is liable for part or all of a Medicaid member's medical expenses, the insurer shall coordinate the benefits with the office and:
(1) pay the provider of service for bills submitted by the provider unless the office certifies that it has already paid the bill;
(2) reimburse the office for claims submitted by the office; or
(3) reimburse the office if the provider and the office submit claims for the same services.

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

(i) Once Medicaid has been reimbursed for the office's claim by the insurer, the insurer has discharged its responsibility for that claim. Neither the insurer nor the member 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 ~~405 IAC 1-1.5~~. **405 IAC 1-1.4.**

(j) The rules set forth in subsection (g) shall also apply when the member notifies the insurer that the member has received Medicaid from the office. In this case, the insurer is required to initiate coordination of benefits with the office.

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

(l) The office 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 p.m.: 5 IR 2322; filed May 22, 1987, 12:45 p.m.: 10 IR 2282, eff Jul 1, 1987; 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; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA) 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.

SECTION 4. 405 IAC 1-1.4 IS ADDED TO READ AS FOLLOWS:

Rule 1.4. Program Integrity and Appeals

405 IAC 1-1.4-1 Scope

Authority: IC 12-8-6.5-5; IC 12-15-1-10; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. (a) This rule outlines the program integrity requirements and appeal procedures relating to all claims paid by Medicaid for services rendered and the actions available against providers.

(b) This rule does not govern determinations by the office with respect to the authorization or approval of Medicaid services requested by a provider on behalf of a member.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-1)

405 IAC 1-1.4-2 Medical records

Authority: 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 records shall be:
(1) of sufficient quality to fully disclose and document the extent of services provided to individuals receiving Medicaid assistance; and
(2) documented at the time the services are provided or rendered, and prior to associated claim submission.

(b) All providers shall maintain, for a period of seven (7) years from the date Medicaid services are provided to a member, such medical or other records as are necessary to fully disclose and document the extent of the services provided. A copy of a claim form that 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 that are independent of claims for reimbursement. Such medical or other records, or both, shall include, at the minimum, the following information and documentation:
(1) The identity of the individual to whom service was rendered.
(2) The identity, including dated signature or initials, of the provider rendering the service.
(3) The identity, including dated signature or initials, and position of the provider employee rendering the service, if applicable.
(4) The date on which the service was rendered.
(5) The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only.
(6) A detailed statement describing services rendered, including duration of services rendered.
(7) The location at which services were rendered.
(8) The amount claimed through Medicaid for each specific service rendered.
(9) Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document the acute medical needs.
(10) When required under Medicaid rules, physician progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and redefine goals.
(11) X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imaging records.

(c) Providers whose reimbursement is determined by the office shall maintain financial records for a period of not less than three (3) years following submission of financial data to the office. A provider shall disclose this financial data when the information is to be used during the rate determination process, as well as during audit proceedings.

(d) Records maintained by providers under subsections (a), (b), and (c) shall be subject to prepayment and postpayment review by the office and shall be openly and fully disclosed and produced to the office upon reasonable notice and request. Such notice and request may be made in person, in writing, or orally. Failure on the part of any provider to comply with this section shall subject the provider to sanctions under IC 12-15-22 and applicable federal law.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-2)

405 IAC 1-1.4-3 Provider enrollment

Authority: 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; IC 12-15-12-21; IC 16-31-2-1; IC 20-27

Sec. 3. (a) In order to receive reimbursement under Medicaid, a provider shall be enrolled to participate as a 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 Medicaid and completed such forms as may be required.

(3) The provider has signed and returned a Medicaid provider agreement.

(4) The provider has received a provider number.

(5) For an institutional or individual provider located out-of-state, such entity shall, in addition to meeting subdivisions (2) through (4), be either:

(A) certified;

(B) licensed;

(C) registered; or

(D) authorized;

as required by the state in which the entity is located.

(6) The provider maintains state licensure and abides by the office's provider agreement.

(7) The provider meets credentialing standards as required in order for the MCO to receive accreditation through the National Committee for Quality Assurance pursuant to IC 12-15-12-21.

(b) In addition to subsection (a), a provider seeking to enroll transportation services shall:

(1) make transportation services available to the general public; and

(2) demonstrate that its primary business function is the provision of transportation services.

This requirement does not apply to transportation providers who provide only ambulance, family member transportation services, or school corporations.

(c) With respect to ambulance service, vehicles and staff that provide emergency services must be certified by the Indiana emergency medical services commission established under IC 16-31-2-1 to be eligible for Medicaid reimbursement for transports involving either advanced life support or basic life support services that are emergent in nature. Failure to maintain the Indiana emergency medical services commission certification on all vehicles involved in transporting Medicaid members will result in termination of the Medicaid provider agreement.

(d) All transportation provider types shall continuously comply with all state statutes, rules, and local ordinances governing public transportation. The following requirements also apply as follows:

(1) A common transportation carrier shall submit proof of, and maintain throughout its period of participation, the following:

(A) Certification by the Indiana motor carrier authority.

(B) Insurance coverage as required by the Indiana motor carrier authority.

(C) Appropriate and valid drivers' licenses for all drivers.

(2) A taxicab transportation entity shall submit proof of and maintain throughout its period of participation the following:

(A) Written acknowledgment 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.

(B) 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.

(C) Appropriate and valid drivers' licenses for all drivers.

(3) A not-for-profit transportation entity shall submit proof of, and maintain throughout its period of participation, the following:

(A) An acknowledgment from state or federal officials of its status as a not-for-profit entity.

(B) A minimum of five hundred thousand dollars ($500,000) of combined single limit commercial automobile liability insurance.

(C) Appropriate and valid drivers' licenses for all drivers.

(e) IEP transportation services provided in accordance with 405 IAC 5-30-11 must conform to the requirements set out in IC 20-27 and are exempt from the transportation provider agreement requirements set out in this section.

(f) The office may enroll the family member of a member only when the member must make frequent trips to medical services and that travel creates undue financial hardship for the family. In order to enroll as a transportation provider, a family member shall do the following:

(1) Comply with and maintain compliance with all enrollment requirements under any federal or state law or rule.

(2) Possess a valid driver's license as required by state law.

(3) Possess coverage of the minimum amount of automobile insurance as required by state law.

(4) Utilize as the vehicle for transporting family members, only a vehicle that has been duly licensed and registered.

(5) Include, at a minimum, the following information in an enrollment request:

(A) The member'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.

(g) A close associate or able-bodied member may enroll to provide transportation services when no family member is available to provide this service. 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 prior authorization. The local division of family resources office, on behalf of the family member, shall submit the enrollment request to the office or its designee for its approval.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-3)

405 IAC 1-1.4-4 Sanctions against providers; determination after investigation

Authority: 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

Sec. 4. (a) If, after investigation by the office, the 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 Medicaid services rendered during a specified period of time as provided under section 8 of this rule.

(2) Reject a prospective provider's application for participation in Medicaid.

(3) Remove a provider's certification for participation in Medicaid (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) Require the provider to create a corrective action plan. A corrective action plan must include the following:

(A) A timeline for coming into compliance with state or federal requirements.

(B) The names, including title, address, and phone number, of persons responsible for ensuring compliance with state or federal requirements.

(C) A description of the actions the entity will take to come into compliance with state or federal requirements.

(D) Any other information required by the office.

If, after sixty (60) calendar days following written notice of a request for a corrective action plan by the state, a provider has not submitted a corrective action plan, the provider may be subject to payment withholding or any other sanction under this rule.

(6) Suspend a provider's Medicaid payments in whole or in part.

(7) Terminate the provider agreement.

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

(1) presented, submitted, or caused to be submitted:

(A) claims for Medicaid services:

(i) that cannot be documented by the provider; or

(ii) provided to a person other than a person in whose name the claim is made;

(B) any false or fraudulent claims for Medicaid services or merchandise;

(C) information with the intent of obtaining greater compensation than that which the provider is legally entitled, including charges in excess of the:

(i) fee schedule; or

(ii) usual and customary charges; or

(D) false information for the purpose of meeting prior authorization requirements;

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

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

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

(5) overutilized, or caused to be overutilized, the Indiana Medicaid program or otherwise caused the member to receive services or merchandise not otherwise required or requested by the member;

(6) submitted, or caused to be submitted:

(A) a false or fraudulent provider agreement;

(B) claims for Medicaid services for which federal financial participation is not available; or

(C) any claims for Medicaid services or merchandise arising out of any act or practice prohibited by the:

(i) criminal provisions of the Indiana Code; or

(ii) rules of the office;

(7) failed to:

(A) disclose or make available to the office, the IMFCU, or other governmental authority, after reasonable request and notice to do so, documentation of services provided to Medicaid members and Medicaid records of payments made therefor;

(B) comply with the requirements of 1902(a)(68) of the Social Security Act, except that such failure shall first be sanctioned with a corrective action plan before any other sanction in subsection (a) shall be applied; or

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

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

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

(10) failed to:

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

(B) repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments in accordance with state or federal law; or

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

(c) The office may impose a sanction under IC 4-21.5-3-6. Any order 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 office 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 office may issue an emergency order imposing a sanction identified in this section 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 order; and

(4) contain a statement that any appeal from the decision of the office 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 office.

(f) Prepayment review of provider claims is not a sanction and is not subject to appeal.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-4)

405 IAC 1-1.4-5 Payment suspension procedures

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

Sec. 5. (a) This rule applies to a credible allegation of fraud defined in 42 CFR 455.2. The office will investigate an allegation of fraud it receives from any source. If, during the course of its investigation, the office determines that there is a credible allegation of fraud against a provider, the office shall:
(1) refer the case to the IMFCU; and
(2) suspend Medicaid payments pursuant to 42 CFR 455.23 and the requirements therein.

(b) Unless otherwise provided, the office shall send a provider notice of the payment suspension in accordance with the procedures in 42 CFR 455.23(b) and subject to the exceptions therein.

(c) A provider or entity subject to payment suspension under subsection (a) may appeal the payment suspension under section 11 or 12 of this rule, as applicable.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-5)

405 IAC 1-1.4-6 Provider exclusions

Authority: 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 12-15-1-22; IC 35-48-1-9

Sec. 6. (a) The following definitions apply throughout this section:
(1) "Conviction" means any of the following:
(A) A judgment has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged.
(B) A finding of guilt against the individual or entity by a federal, state, or local court.
(C) A plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court.
(D) The individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.
(2) "Failure to grant immediate access" means the failure to grant access at the time of a reasonable request. The office shall deem a provider's failure to appear at the site requested to be a failure under this definition.
(3) "Indirect ownership interest" means an ownership interest through any other entities that ultimately have an ownership interest in the entity at issue.
(4) "Ownership interest" means an interest in either:
(A) the capital, stock, or profits of the entity; or
(B) any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.
(5) "Reasonable request" means a written request that is made by a properly identified agent of:
(A) a federal agency;
(B) a state survey agency;
(C) the office;
(D) IMFCU; or
(E) another authorized entity;
during hours that the facility is open for business within a sufficient amount of time for the provider to comply.

(b) The office may exclude a provider from participation in Medicaid for the time period provided in subsection (c) for the following reasons:

(1) For any reason outlined in 42 CFR 1002.3.

(2) The provider has been convicted of a misdemeanor in a federal or state court relating to:

(A) fraud;

(B) theft;

(C) embezzlement;

(D) breach of fiduciary responsibility; or

(E) other financial misconduct;

in connection with the delivery of any health care program, operated by, or financed in whole or in part by, any federal, state, or local government agency.

(3) The provider has been convicted, under federal or state law, in connection with the interference or obstruction of any investigation into criminal conduct or a credible allegation of fraud.

(4) A provider has been convicted under state law for the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, as defined under IC 35-48-1-9.

(5) A provider has either:

(A) had its license to provide health care revoked or suspended by any state licensing authority, or has otherwise lost such license, including the right to apply for or renew such license, for reasons bearing on the provider's professional competence, professional performance, or financial integrity; or

(B) surrendered the license while a formal disciplinary proceeding concerning the provider's competence, professional performance, or financial integrity was pending before a state licensing authority.

(6) The provider was suspended, excluded, or otherwise sanctioned under:

(A) any federal program involving the provision of health care;

(B) Medicaid; or

(C) any state health care program;

for reasons bearing on the individual or entity's professional performance, professional competence, or financial integrity.

(7) The office determines that a provider has either:

(A) submitted, or caused to be submitted, claims or requests for payments under Medicaid containing charges or costs for items or services that are greater than the provider's usual and customary charges or costs for such items or services;

(B) furnished, or caused to be furnished, to patients, whether or not covered by Medicare or Medicaid, any items or services in excess of the patient's needs, or of a quality that fails to meet professionally recognized standards of health care;

(C) knowingly submitted false claims, statements, or documents; or

(D) knowingly concealed material facts.

(8) A provider that has violated one (1) of the following:

(A) 42 U.S.C. 1320a-7a.

(B) 42 U.S.C. 1320a-7b.

(9) A provider who has a business relationship with an individual who has a conviction for any of the following:

(A) Neglect or abuse of patients in connection with the delivery of a health care item or service.

(B) A felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct relating to the delivery or provision of an item or service under Medicaid.

(C) A felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance relating to the delivery or provision of an item or service in connection with Medicaid.

(D) Other misconduct related to the delivery or provision of an item or service under Medicaid.

(10) A provider who has a business relationship with an individual who has had civil monetary penalties or assessments imposed under 42 U.S.C. 1320a-7a.

(11) A provider who has a business relationship with an individual who meets both of the following conditions:

(A) Has been excluded from participation in Medicare or any state health care programs.

(B) Meets any of the following:

(i) Has a direct or indirect ownership interest of five percent (5%) or more in the provider.

(ii) Is the owner of a whole or part interest in any mortgage, deed or trust, note or other obligation secured (in whole or in part) by the provider or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets of the

provider.
(iii) Is an officer or director of the provider, if the provider is organized as a partnership.
(iv) Is an agent of the provider.
(v) Is a managing employee who is:
(AA) a general manager;
(BB) a business manager;
(CC) an administrator; or
(DD) a director;
who exercises operational or managerial control over the provider or part thereof, or directly or indirectly conducts the day-to-day operations of the provider or part thereof.

(12) A provider who fails to fully, accurately, or completely make the disclosures required under 42 CFR 455 Part B.

(13) A provider who furnishes items or services for which payment may be made under Medicare or Medicaid and:
(A) fails to provide such information as is necessary to determine whether such payments are or were due and the amounts thereof; or
(B) has refused to permit such examination and duplication of its records as may be necessary to verify such information.

(14) Failure to grant immediate access, upon reasonable request, to any of the following:
(A) The state survey agency, or other authorized entity for the purpose of making any of the determinations provided in 42 CFR 1001.1301(a)(1).
(B) ISDH for purposes of conducting reviews and surveys of:
(i) ICFs/IID;
(ii) nursing facilities; or
(iii) providers of home and community care and community care settings.
(C) The IMFCU for purposes of conducting its activities.
(D) The office for purposes of conducting any of the following:
(i) An audit.
(ii) Investigation.
(iii) A site visit pursuant to IC 12-15-1-22 and 42 CFR 455.432.
(iv) Any other action permitted by state or federal law.

(c) The length of a provider's exclusion for the Indiana Medicaid program for any reason specified under this rule shall be three (3) years following the date of exclusion unless:
(1) federal or state law requires a longer or shorter exclusionary period;
(2) the provider has been permanently excluded from participating as a provider;
(3) the provider enters into an agreement to accept a longer period or permanent exclusion from Medicaid;
(4) the office determines that a mitigating factor outlined in subsection (d) justifies a lesser sanction period;
(5) the provider's license remains in a revoked or suspended status;
(6) the state licensing agency reinstates the provider's revoked or suspended license before the end of the three (3) year period;
(7) the circumstances concerning the provider's refusal to grant immediate access under subsection (b)(12) and its impact on Medicaid, beneficiaries, or the public warrant a different exclusion period; or
(8) the office determines that a longer or shorter exclusion period is more appropriate under subsection (d).

(d) When permissible, the office, when assessing an exclusion period other than three (3) years may consider the following:
(1) Nature of the offense.
(2) Sentence imposed by a court.
(3) Provider's criminal history.
(4) Provider's cooperation with federal or state officials in the investigation.
(5) Impact of the provider's misconduct on the Indiana Medicaid program.
(6) Provider's history of noncompliance with federal or state officials.
(7) Needs of the Indiana Medicaid program.

(e) The sanction period shall begin fifteen (15) days from the date the office mails notice to the provider of the grounds for the exclusion.

(f) A provider excluded under this section may reapply for enrollment in order to again participate in Medicaid. The provider may not request to be reenrolled until after the exclusion period has passed. The office may grant an application for reenrollment only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. In making this determination, the office shall consider the following:

(1) The conduct of the individual or entity occurring prior to the date of the notice of exclusion, if not known to the agency at the time of the exclusion.

(2) The conduct of the individual or entity after the date of the notice of exclusion.

(3) Whether all fines, and all debts due and owing, including overpayments to any federal, state, or local government that relate to Medicaid or any of the state health care programs, have been paid, or satisfactory arrangements have been made, that fulfill these obligations.

A provider reinstated under this section shall be considered a high risk provider for purposes of 42 CFR 455.450 and IC 12-15-1-22.

(g) A provider may appeal the office's determination to impose an exclusion or to deny its request for reinstatement in accordance with the appeal procedures in section 11 of this rule and IC 4-21.5.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-6)

405 IAC 1-1.4-7 Prepayment review

Authority: 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

Sec. 7. (a) Prepayment review is a manual claims review process that allows for:

(1) review of claims for appropriate coding and documentation; and

(2) education on appropriate billing practices.

(b) Prepayment review of claims is not a sanction and is not subject to appeal. Providers may be added to or removed from prepayment review at the discretion of the office. Providers released from prepayment review may be subject to future follow-up reviews to ensure continued compliance with the Indiana Administrative Code, any other applicable rules and regulations, and all rules and guidelines set forth in the Indiana Health Coverage Programs (IHCP) provider Reference Modules and all other IHCP publications, including, but not limited to, bulletins and banner pages.

(c) The office shall implement prepayment review for a period of six (6) months as follows:

(1) The six (6) month period begins upon the first successful adjudication of a claim submission under prepayment review.

(2) As part of the prepayment review process, providers are required to send supporting documentation for each claim submission.

(3) If the supporting documentation in subdivision (2) is not submitted, the claim shall be denied.

(d) During the review period, the office shall conduct a review of the following:

(1) Services were provided according to Medicaid policy requirements.

(2) The billed services were medically necessary, appropriate, and not in excess of the member's need pursuant to a physician order as documented in policy or services standards.

(3) The number of visits and services delivered are logically consistent with the member's characteristics and circumstances, such as type of illness, age, gender, and service location.

(4) The provider and member were Medicaid-eligible on the date the service was provided.

(5) Prior authorization was obtained if required by policy.

(6) The provider's staff was qualified as required by state or federal law.

(7) The provider possessed the proper license, certification, or other accreditation requirements specific to the provider's scope of practice and Medicaid policy at the time the service was provided to the member.

(8) The claim does not duplicate or conflict with one reviewed previously or currently being reviewed.

(9) The payment does not exceed any reimbursement rates or limits in the state plan.

(10) Third-party liability within the requirements of 42 CFR 433.137 is appropriately billed and accounted for.

(e) On completion of the review period:
(1) the office shall review the provider for release from prepayment review if:
(A) the provider has achieved an eighty-five percent (85%) or more approval rate on claim submissions for three (3) consecutive months; and
(B) the volume of its claim submissions remained within ten percent (10%) of its volume before prepayment review;
(2) if the provider successfully completes both requirements under subdivision (1) before the six (6) month deadline, they may be removed from the prepayment review process at the discretion of the office;
(3) the provider shall remain on prepayment review for an additional period of six (6) months, and may be required to submit a corrective action plan, if it fails to satisfy either requirement under subdivision (1); and
(4) if after the second six (6) month interval prescribed under subdivision (3) the provider fails to satisfy the requirements under subdivision (1), the office may do the following:
(A) Deny payment for medical assistance services rendered during a specified period of time.
(B) Terminate the provider agreement.
(C) Require a corrective action plan.
(D) Impose other sanctions as provided in section 4 of this rule.

(f) If a provider has been on prepayment review for twelve (12) months the office may terminate the provider agreement if:
(1) there has been no billing activity for six (6) consecutive months; or
(2) the volume of its claim submissions during the review period was not within ten percent (10%) of its volume before prepayment review.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-7)

405 IAC 1-1.4-8 Denial of claim payment procedures

Authority: 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

Sec. 8. (a) The office may deny payment to any provider for Medicaid 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 IMFCU, or other governmental authority, the office finds any of the following:
(1) The claims were made for services or materials determined by the office, the IMFCU, or other governmental authority as not medically necessary.
(2) The amount claimed for such services or materials has been or can be paid from other sources.
(3) The services claimed were provided to a person who was not eligible for Medicaid at the time of the provision of the service.

(b) The decision as to denial of payment for a particular claim or claims is at the discretion of the office. This decision shall be final and:
(1) shall 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) shall be effective upon receipt; and
(3) may be administratively appealed under section 11 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-8)

405 IAC 1-1.4-9 Provider audits; overpayments; 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; IC 12-15-21-3; IC 12-15-23-2

Sec. 9. (a) Under IC 12-15-21-3(5) and IC 12-15-21-3(7), the office may recover payment from any

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 section 2 of this rule;

(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 Medicaid 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) the overpayment resulted from:

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

(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;

(C) duplicate billing; or

(D) claims for services or materials determined to have been not medically reasonable or necessary; or

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

(b) The office shall determine the look-back period for audits as follows:

(1) For audits initiated on or before June 30, 2019, the audit look-back period shall be seven (7) years.

(2) For audits initiated on or after July 1, 2019, the audit look-back period shall be three (3) years and ninety (90) days.

(3) The audit look-back period accounts for and includes the timely filing period described in 405 IAC 1-1-3 for determining the available audit dates.

(4) The look-back date begins on the date of audit initiation or when the office discovers a credible allegation of fraud or abusive billing practices, whichever is earliest.

(c) The office shall limit its audit to claims submitted and paid by the office during the appropriate look-back period. Once the office begins its audit, all claims within the audit look-back period remain viable for audit and recoupment throughout the audit and appeal process.

(d) If the office discovers information that may indicate a credible allegation of fraud or abusive billing practices, or a claims processing error rate greater than thirty percent (30%), it may increase the audit look-back period from three (3) years and ninety (90) days to seven (7) years.

(e) Underpayments discovered by the office in the course of an audit shall be accounted for as follows:

(1) The sum of such underpayments shall reduce the sum of overpayments identified in the audit.

(2) The provider, at its own expense, may elect to examine the claims under audit for underpayments. If the provider identifies underpayments, then the sum of those underpayments, if verified by the office, shall reduce the sum of overpayments identified.

(3) Underpayments shall only reduce overpayment findings.

(f) Under IC 12-15-21-3(5), the office may determine the amount of overpayment made by a provider by means of a random sample and extrapolation audit. The office shall conduct the random sample and extrapolation audit in accordance with generally accepted statistical methods, and shall base the selection criteria on a random sampling methodology generally accepted by the statistical profession.

(g) In the event that the provider wishes to appeal the accuracy of the random sampling methodology, the provider may either:

(1) 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; or

(2) 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 shall:

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

(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, subject to review and approval by the office, to demonstrate this compliance.

(h) If the office determines that an overpayment has occurred, the office shall notify the provider by certified mail. A provider who receives a notice may elect to do one (1) of the following:

(1) Repay the amount of the overpayment pursuant to IC 12-15-13-3.5(e) for a noninstitutional provider or IC 12-15-13-4(e) for an institutional provider.

(2) Request a hearing and repay the amount of the alleged overpayment pursuant to IC 12-15-13-3.5(e) for a noninstitutional provider or IC 12-15-13-4(e) for an institutional provider.

(i) The office shall initiate recoupment proceedings to collect any overpayment that is not repaid within three hundred (300) calendar days after the provider's receipt of the final calculation notice under section 11(d) or 12(e) of this rule as applicable. The office may recoup an overpayment until it is satisfied through any of the following methods:

(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.

(j) The office shall assess an interest charge in addition to the amount of overpayment identified in the notice of overpayment provided in subsection (d). Such interest charge shall not exceed the percentage set out in IC 12-15-13-3.5(g) for a noninstitutional provider or IC 12-15-13-4(h) for an institutional provider. 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:

(A) from the date of the overpayment to the provider; or

(B) for extrapolated overpayments, from the last paid date of the audit period;

(2) apply to the net outstanding overpayment during the periods in which such overpayment exists; and

(3) be assessed even if the provider repays the overpayment to the office within thirty (30) days after receipt of the notice of the overpayment.

(k) 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 shall pay to the provider interest on the amount erroneously recovered from the provider. Such interest shall accrue:

(1) from the date that the office recovered the overpayment until the date the overpayment is restored to the provider; and

(2) at the rate of interest that shall not exceed the rate set out in IC 12-15-13-3.5(g) for a noninstitutional provider or IC 12-15-13-4(h) for an institutional provider.

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 shall pay interest to the hospital on the amount of the underpayment beginning on the date of the underpayment at the rate outlined in subsection (f)(2).

(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, 405 IAC 1-14.5, or 405 IAC 1-14.6 as a result of an audit.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-9)

405 IAC 1-1.4-10 Provider payments during pendency of applicant or member appeals; recovery

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-13-2; IC 12-15-13-3.5; IC 12-15-13-4

Sec. 10. (a) The office may recover payment from any 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 as follows:

(1) When the office is required by 42 CFR 431.230(a) to maintain services to a member during the pendency of an appeal, and the hearing decision is favorable to the office.

(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 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) CRFs/DD.
(4) ICFs/IID.

(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 12-15-13-3.5(g) for a noninstitutional provider or IC 12-15-13-4(h) for an institutional provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-10)

405 IAC 1-1.4-11 Appeal requests; noninstitutional providers

Authority: IC 12-15-21
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7; IC 12-8-6.5-6; IC 12-15-13-3.5

Sec. 11. (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. In accordance with IC 12-8-6.5-6, the office is the ultimate authority for purposes of this section.

(b) As used in this section, a "noninstitutional provider" means any Medicaid provider defined in IC 12-15-13-3.5.

(c) Under IC 12-15-13-3.5, if the office believes that an overpayment to a noninstitutional provider has occurred, the office may submit a written notice of preliminary draft audit finding of overpayment to the provider. A noninstitutional provider that receives the preliminary audit findings may:
(1) request administrative reconsideration of the preliminary audit findings within forty-five (45) calendar days from the date of the notice of preliminary findings, along with all comments and additional documentation to support the request; or
(2) submit a written statement waiving the right to request administrative reconsideration or an appeal and accepting the preliminary calculations as final.

(d) If the office determines, after having reviewed a noninstitutional provider's timely request for reconsideration, that an overpayment occurred, the office shall notify the provider in writing of the final calculation of overpayment. A noninstitutional provider may contest the office's determination by filing an appeal with the office within sixty (60) calendar days from the date of the notice of final calculation of overpayment.

(e) The noninstitutional provider appealing a final calculation of an overpayment must file with the office a statement of issues:
(1) within sixty (60) calendar days after the provider receives notice of the final calculation of overpayment; or
(2) at the time the provider files a timely request for appeal;
whichever is later.

(f) 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, in accordance with IC 4-21.5-3-7.

(g) For all other appeal requests, the noninstitutional provider must file with the office a statement of issues:
(1) within forty-five (45) calendar days after the provider receives notice of the adverse agency action;

or
(2) at the time the noninstitutional provider files a timely request for an appeal;
whichever is later.

(h) If a deadline for filing under this section is a:
(1) Saturday;
(2) Sunday;
(3) state holiday; or
(4) day the office in which the act is to be done is closed during regular business hours;
the filing must be received by the office by close of business the next business day. A filing received after close of business on date of the deadline is invalid and will result in the waiver of any right to appeal the office's determination. For purposes of this section, "close of business" means 5:00 p.m., local time, on the business day where the filing is received.

(i) An appeal filed under this section must state facts demonstrating that the petitioner is:
(1) a person to whom the order is specifically directed;
(2) aggrieved or adversely affected by the order; or
(3) entitled to review under any law.

(j) 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
(B) all statutes or rules supporting the provider's contentions of error.

(k) 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) specific findings, action, or determination of the office; or
(2) reason or rationale supporting the provider's appeal.

(l) 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.

(m) 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.

(n) Failure of the provider to timely file a statement of issues within the timelines provided in subsection (i) will result in automatic certification to the secretary for summary review, in accordance with section 3 of this rule.

(o) Notwithstanding subsections (h) through (k), 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 1-1.4-11)

405 IAC 1-1.4-12 Appeal requests; institutional providers

Authority: IC 12-15-21
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7; IC 12-8-6.5-6; IC 12-15-13-4

Sec. 12. (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 office in accordance with IC 12-8-6.5-6.

(b) As used in this section, an "institutional provider" means any Medicaid provider defined in IC 12-15-13-4.

(c) Under IC 12-15-13-4, if the office believes that an overpayment to an institutional provider has occurred, the office may:
(1) submit a written notice of preliminary draft audit findings of overpayment to the provider; and
(2) accept and consider any written comments submitted by the institutional provider regarding the preliminary draft audit and finalize the audit findings and issue a preliminary recalculated Medicaid rate.

(d) An institutional provider that receives the preliminary recalculated Medicaid rate under subsection (c)(2) may:
(1) request administrative reconsideration of the preliminary audit findings within forty-five (45) calendar days from the date of the notice of recalculated Medicaid rate; or
(2) submit a written statement waiving the right to request administrative reconsideration or an appeal and accepting the preliminary calculations as final.

(e) If the office believes, after having reviewed an institutional provider's request for reconsideration, that an overpayment occurred, the office shall notify the provider in writing a notice of final calculation of overpayment. An institutional provider may contest the office's final determination by filing an appeal with the office within sixty (60) calendar days from the date of the notice of final calculation.

(f) 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, in accordance with IC 4-21.5-3-7.

(g) The deadlines outlined under section 11(f) of this rule shall apply to an appeal filed under this section.

(h) An appeal must include the elements listed under section 11(g) of this rule.

(i) The institutional provider appealing a final calculation of an overpayment must file with the office a statement of issues:
(1) within sixty (60) calendar days after the provider receives notice of the final calculation of overpayment; or
(2) at the time the provider files a timely request for appeal;
whichever is later.

(j) For all other appeal requests, the institutional provider must file with the office a statement of issues:
(1) within forty-five (45) calendar days after the provider receives notice of the adverse agency action; or
(2) at the time the institutional provider files a timely request for an appeal;
whichever is later.

(k) The provisions of section 11(j) through 11(o) of this rule shall apply to a provider's statement of issues.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.4-12)

405 IAC 1-1.4-13 Summary review

Authority: IC 12-15-21

Affected: IC 4-21.5-3

Sec. 13. (a) The office shall provide a summary review 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 all or part of the general methodology or criteria utilized by the office for:

(1) setting rates;

(2) audits;

(3) making determinations with respect to change of provider status for purposes of setting a rate of reimbursement;

(4) determination that an overpayment has been made to a provider due to a year-end cost-settlement; shall 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 shall 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) There shall be no appeal from a determination by the office certifying any issues for summary review.

(d) Upon a determination of the office that any or all of the issues in the provider's statement of issues concern those items listed in subsection (a), the office shall certify those issues for summary review. With respect to each issue certified by the office, the office shall, with respect to the office's determination:

(1) affirm;

(2) dissolve; or

(3) remand the decision to an administrative law judge for an evidentiary hearing.

(e) The decision of the office on summary review shall be rendered within forty-five (45) calendar days after certification by the office.

(f) The office shall send a notice of the decision on summary review to the provider. The decision on summary review of the office 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 office 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 1-1.4-13)

SECTION 5. 405 IAC 1-17-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-18 Administrative reconsideration; appeal

Authority: 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 office 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 office. 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 office within forty-five (45) days after release of the rate computed by the office. Upon receipt of the request for reconsideration, the office shall evaluate the data. After review, the office may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The office shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the office's receipt of the request for reconsideration. In the event that a timely response is not made by

the office 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 office. 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 office within forty-five (45) days after release of the rate computed by the office. Upon receipt of the request for reconsideration, the office shall evaluate the data. After review, the office may amend the audit adjustment or affirm the original adjustment. The office shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office 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.~~ **405 IAC 1-1.4.**

(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; 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)

SECTION 6. 405 IAC 2-3.3-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 2-3.3-4 Administrative appeals

Authority: IC 12-15-2.3-12; IC 12-15-21
Affected: IC 4-21.5-3

Sec. 4. (a) A qualified hospital may appeal the office's revocation of its presumptive eligibility status under the provisions of ~~405 IAC 1-1.5.~~ **405 IAC 1-1.4.**

(b) The following actions are not sanctions and are not appealable:
(1) The office's decision to issue a warning to a qualified hospital and to require a corrective action plan.
(2) The office's decision not to exercise its discretion to lift a hospital's request for reinstatement under section 3(e) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3.3-4; filed Sep 14, 2015, 2:07 p.m.: 20151014-IR-405130497FRA)

SECTION 7. 405 IAC 5-21.7-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-21.7-14 Provider sanctions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-15; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 14. (a) Under ~~405 IAC 1-1.6,~~ **405 IAC 1-1.4-4,** if a provider has violated any provision established under IC 12-15, the ~~office~~ **OMPP** may impose one (1) or more of the following sanctions:
(1) Deny payment.
(2) Revoke authorization as a CMHW services provider.
(3) Assess a fine.
(4) Assess an interest charge.
(5) Require corrective action against an agency or a provider.

(b) The loss of ~~office~~ **DMHA** authorization for a provider to deliver CMHW services may occur due to, but not limited to, the following:

(1) The provider's failure to adhere to and follow CMHW services policies and procedures for behavior, documentation, billing, or service delivery.

(2) The provider's failure to respond to or resolve a corrective action imposed upon the provider by the ~~office~~ **DMHA or the OMPP** for noncompliance with CMHW services' policies and procedures.

(3) The provider's failure to maintain CMHW services provider qualifications, ~~office-required~~ **DMHA-required** training, or standards contained in this rule for the CMHW service or services the provider is authorized to provide.

(4) The provider's failure to timely reapply for CMHW services provider authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-14; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 8. THE FOLLOWING ARE REPEALED: 405 IAC 1-1-4; 405 IAC 1-1-5; 405 IAC 1-1-5.1; 405 IAC 1-1-6; 405 IAC 1-1.5; 405 IAC 1-5; 405 IAC 5-4-1; 405 IAC 5-4-2; 405 IAC 5-4-3.

Notice of Public Hearing

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