TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #18-375

DIGEST

Amends 405 IAC 5-27-1, 405 IAC 5-27-2, 405 IAC 5-27-3, and 405 IAC 5-27-6 to correct terminology and adjust utilization criteria. Adds 405 IAC 5-27-7, 405 IAC 5-27-8, and 405 IAC 5-27-9 to allow for other radiology services. Effective 30 days after filing with the Publisher.

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

405 IAC 5-27-1; 405 IAC 5-27-2; 405 IAC 5-27-3; 405 IAC 5-27-6; 405 IAC 5-27-7; 405 IAC 5-27-8; 405 IAC 5-27-9

SECTION 1. 405 IAC 5-27-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-27-1 Reimbursement limitations

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

Sec. 1. (a) Medicaid reimbursement is available to radiology inpatient and outpatient facilities, freestanding clinics, and surgical centers for services provided to ~~members~~ **recipients** subject to the following limitations:

(1) Prior authorization is required for any radiological services that exceed the utilization parameters set out in this article.

(2) To be eligible for reimbursement, a radiological service must be ordered in writing by a physician or other practitioner authorized to do so under state law.

(3) Radiological service facilities must bill Medicaid directly for components provided by the facility. When two (2) practitioners separately provide a portion of the radiology service, each practitioner shall bill Medicaid directly for the component he or she provides. Medicaid will reimburse a physician or other practitioner for radiological services only when such services are performed under the physician's or practitioner's direct supervision.

(b) Radiology procedures cannot be fragmented and billed separately. Such procedures may include, but are not limited to, the following:

(1) CPT codes for supervision and interpretation procedures will not be reimbursed when the same provider bills for the complete procedure CPT code.

(2) If two (2) provider specialties are performing a radiology procedure, the radiologist shall bill for the supervision and interpretation procedure with the second physician billing the appropriate injection, aspiration, or biopsy procedure.

(3) Angiography procedures when performed as an integral component of a surgical procedure by the operating physician will not be reimbursed. Such procedures include, but are not limited to, the following:

(A) Angiography injection procedures during coronary artery bypass graft.

(B) Peripheral percutaneous ~~transbiminal~~ **transabdominal** angioplasty procedures.

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3350; 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 Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

SECTION 2. 405 IAC 5-27-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-27-2 Utilization criteria

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

Sec. 2. Criteria for utilization of radiological services shall include consideration of the following:

(1) Evidence that this radiologic procedure is necessary for the appropriate treatment of illness or injury.

(2) X-rays of the spinal column are limited to cases of acute documented injury or a medical condition where interpretation of x-ray films would make a direct impact on the medical/surgical treatment.
(3) Medicaid reimbursement is available for x-rays of the extremities and spine for the study of neuromusculoskeletal conditions.
(4) Radiologic procedures must be limited to the minimum number of views or films in order to appropriately diagnose or assess a patient condition. Procedures must also be limited to the most appropriate body part or area to provide or rule out a diagnosis for the suspected condition.
~~(4)~~ **(5)** Medicaid reimbursement is not available for radiology examinations of any body part taken as a routine study not necessary ~~to~~ **for** the diagnosis or treatment of a medical condition. ~~Situations generally not needing radiologic services include, but are not limited to, the following:~~
~~(A) Pregnancy.~~
~~(B) Research studies.~~
~~(C) Screening.~~
~~(D) Routine physical examinations or check-ups.~~
~~(E) Premarital examinations.~~
~~(F) Fluoroscopy without films.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3351; 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)

SECTION 3. 405 IAC 5-27-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-27-3 Computerized tomography; general

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

Sec. 3. (a) Medicaid reimbursement may be available for diagnostic examination of the head (head scan) and of other parts of the body (body scans) performed by computerized tomography (CT) scanners, subject to the following restrictions:
(1) The scan should be reasonable and necessary for the individual patient.
(2) The use of a CT scan must be found to be medically ~~appropriate~~ **necessary** considering the patient's symptoms and preliminary diagnosis.
(3) Reimbursement will be made only for CT scans that have been performed on equipment that has been certified by the Food and Drug Administration.
(4) Whole abdomen, or whole pelvis on greater than twenty (20) cuts will not be reimbursed except in staging cancer for treatment evaluation.

(b) Prior authorization is not required for CT scans.

(c) Reimbursement is not available for CT scans that include both with and without contrast studies.

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3351; 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)

SECTION 4. 405 IAC 5-27-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-27-6 Sonography

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

Sec. 6. (a) Medicaid reimbursement is available for **the following** sonography **procedures:**
(1) Sonography exams performed during pregnancy when warranted by one (1) or more of the following conditions:
~~(1)~~ **(A)** Early diagnosis of ectopic or molar pregnancy.
~~(2)~~ **(B)** Placental localization associated with abnormal bleeding.
~~(3)~~ **(C)** Fetal postmaturity syndrome.

~~(4)~~ **(D)** Suspected multiple births.
~~(5)~~ **(E)** Suspected congenital anomaly.
~~(6)~~ **(F)** Polyhydramnios or oligohydramnios.
~~(7)~~ **(G)** Fetal age determination if necessitated by:
~~(A)~~ **(i)** discrepancy in size versus fetal age; or
~~(B)~~ **(ii)** lack of fetal growth or suspected fetal death.
~~(8)~~ **(H)** Guide for amniocentesis.
(I) Suspected uterine and pelvic abnormality.
(J) Determination of fetal position.
(K) Evaluation of cervix for risk of preterm loss or birth.
(2) Venous Doppler exams for blood flow.
(3) Diagnostic exams of soft tissues or organs.
(4) Echocardiograms.
(5) Other sonography exams as determined by the office.

(b) Reimbursement is available for sonography for fetal age determination prior to therapeutic abortions when the age of the fetus cannot be determined by the patient's history and physical examination and the information is essential for the selection of the abortion method.

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3352; 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)

SECTION 5. 405 IAC 5-27-7 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-27-7 Positron emission tomography

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

Sec. 7. (a) As used in this section, "positron emission tomography" or "PET" scan means any diagnostic test that utilizes a radioactive substance to look for disease in the body or staging of a disease. This also includes any combined radiologic exam, such as a computerized tomography (PET-CT) exam or magnetic resonance (PET-MR) exam.

(b) Prior authorization shall be required for all PET scans.

(c) Medicaid reimbursement may be available for PET scans performed for medically necessary conditions as determined by the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-7)

SECTION 6. 405 IAC 5-27-8 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-27-8 Interventional radiology

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

Sec. 8. (a) Medicaid reimbursement may be available for interventional radiology procedures as determined medically necessary by the office.

(b) Prior authorization shall be required for interventional radiologic procedures as determined by the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-8)

SECTION 7. 405 IAC 5-27-9 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-27-9 Magnetic resonance exams

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

Sec. 9. Medicaid reimbursement shall be available for medically necessary magnetic resonance imaging and magnetic resonance angiography exams.

(Office of the Secretary of Family and Social Services; 405 IAC 5-27-9)

Notice of Public Hearing

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